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**IN THE COURT OF APPEALS, DIVISION I,
OF THE STATE OF WASHINGTON**

No. 62711-2-I

**In the Matter of the
GUARDIANSHIP OF SANDRA LAMB**

GUARDIANS' OPENING BRIEF

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WSBA #28172**

February 23, 2009

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II. STATEMENT OF THE CASE.

The Appellants and Respondents on Cross-Appeal are James R. Hardman, J.D., C.P.G. and Alice L. Hardman, M.S.W., C.P.G. The Respondent and Cross-Appellant is the State of Washington, Department of Social and Health Services (DSHS).[1] Sandra Lamb (Sandy) and Rebecca are both residents of Fircrest School. CP 21, 110. Sandy was born in 1956 and is now 52 years old. CP 115. She is a person with developmental disability with a medical diagnosis of "profound mental retardation".[2] *Id.* She is also a person with multiple disabilities including limited speech and articulation, mild microcephaly, hearing loss, and hemiplegia. *Id.* Rebecca was also born in 1956 and is also a person with developmental disability with a diagnosis of "profound mental retardation." CP 26. She is also a person of no speech, autism, mircocephaly, self-injurious behavior and aggression. *Id.* Both have lived at Fircrest for many years. Rebecca was admitted in 1984, CP 7, and

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[1] James R. Hardman is also "of counsel" to the firm bringing this appeal.

[2] Many disabilities rights advocates oppose the use of the term "mental retardation". Unfortunately, it is a term of art in federal law, and some state statutes still retain the term.

Sandy since 1964, CP 101.[3]

James R. Hardman and Alice L. Hardman are Co-Guardians with independent authority for Sandy and Rebecca. CP 56, 150.

Rebecca's Guardians' Report was filed on May 9, 2008, CP 20-54, and approved on June 6, 2008, CP 58-59. Sandy's Guardian Report was filed on April 16, 2008 and refilled on May 2, 2008, CP 109-146, and also approved in June 6, 2008, CP 148-149. Each Report is sworn under oath and includes an attached "Advocacy Report of James R. Hardman" for the period through February 2, 2008.[4] CP 39-54; 130-145.

A Supplement to Guardian's Report Regarding Guardian Fees was filed. CP 188-190. A Declaration of James R. Hardman regarding his hourly rate of guardian fees was filed. CP 192-195. Finally, a Guardians' Supplemental Declaration regarding Ongoing Advocacy Activities was filed. CP 196-202. The Reports and Declarations are incorporated by reference as if fully set forth here and describe in detail the advocacy undertaken by the Guardians in defending the Sandy's and Rebecca's civil and Constitutional rights. There were no opposing declarations filed by

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[3] Sandy was moved during "downsizing" in 2004 to Rainier School, another residential habilitation center in Buckley, Washington. The Guardians filed suit for damages under the Abuse of Vulnerable Adults Act, Chapter 74.34 RCW. The Guardians obtained a settlement exceeding $ 300,000 for 3 residents forcibly moved, and much smaller amounts for 2 others. Sandy was eventually readmitted to Fircrest and is doing much better now.

[4] The date 2007 is a scrivener's error.

DSHS.

At the hearing on June 6, 2008, the Court Commissioner Eric Watness approved the Reports and approved the guardian fees requested. CP 58-59; CP 148-149. The Commissioner awarded $ 175.00 per month as an advance guardian fee allowance for routine services, and an additional $ 150.00 per month advance guardian fee allowance for special advocacy activities. *Id.* The Commissioner, however, as a condition to approving these fee allowance, required the Guardians at the next guardian's report, when the fees would be subject to approval, to "submit a report specifically reporting the time spend on advocacy and specifically relating the benefit conferred by that advocacy" on Sandy and Rebecca. *Id.*

A Motion to Revise was filed by DSHS. CP 206-215. A Response was filed by the Guardians. CP 216-228. The Response includes a transcript prepared by counsel for the Guardians of the hearing before the Commissioner. CP 226-228. A hearing was held on August 28, 2008 before Judge Steven Gonzales. CP 233. A presentation hearing was held on September 5, 2008. CP 234.[5] The resulting order found that "political

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[5] The Guardians were under the impression a court reporter was taking the record of the August 28, 2008 hearing because the hearing was delayed pending arrival. The record of the hearing appears to be lost and no record was apparently kept of the September 5, 2008 hearing.

and lobbying activities are outside the scope of their [sic] guardianship of Ms. Lamb. The Guardian's request for extraordinary fees for the next reporting period is denied to the extent that those fees relate to political and lobbying activities." CP 236. The Guardians were permitted extraordinary fees for community outreach and awarded fees of $ 75 per month for special advocacy fees. CP 236.

The Guardians filed a Motion for Reconsideration and a Brief in Support. CP 238-261, 262. DSHS filed a Response, CP 257-281, and the Guardians filed a Reply, CP 282-288. The Court denied the Motions without further elaboration. CP 289-292. Notices of Appeal and Cross-Appeal were timely filed.

III. ANALYSIS.

Standard of Review: De Novo Review of the Motion to Revise.[6]

This Court reviews the superior court's ruling, not the commissioner's. All commissioner rulings are subject to revision by the superior court. RCW 2.24.050; see also CONST. art. IV, § 23. Once the superior court makes a decision on revision, the appeal is from the superior court's decision, not the commissioner's. *State v. Hoffman*, 115

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[6] Different standards of review may apply in any given guardianship case depending on the type of decision. However, review of appointment of a guardian, removal of a guardian, the necessity for appointing a guardian ad litem, or findings of incapacity, or the like are not raised in this appeal.

Wn. App. 91, 101, 60 P.3d 1261 (2003). The superior court's decision is reviewed *de novo*. *In the Matter of the Marriage of Langham and Kolde*, 153 Wn.2d 553, 106 P.3d 212 (2005).

The commissioner, a superior court judge, and now this Court review guardianship matters to ensure the best interests of the incapacitated person are protected. "[U]ltimately it is the court's duty to protect the ward's interests. The court having jurisdiction of a guardianship matter is said to be the superior guardian of the ward, while the person appointed guardian is deemed to be an officer of the court." *Seattle-First National Bank v. Brommers*, 89 Wn.2d 190, 200, 570 P.2d 1035 (1977).

ISSUE 1: State Law and Public Policy Impose Duties on Guardians to Engage in Advocacy for Sandy's and Rebecca's Constitutional Rights.

Guardians have a duty of advocacy concerning the residence, health care, treatment and services of the incapacitated persons. There is no uniform rule imposing a limitation on a guardians' advocacy, and there should be none. Guardianship cases sound in equity, and in adjudication of equitable issues "the focus remains on the equities involved between the parties" as opposed to status of guardian and government agency. *Vasquez v. Hawthorne*, 145 Wn.2d 103, 107-08, 33 P.3d 735 (2001).

Rather than relying on analogy, equitable claims must be analyzed under the specific facts presented in each case." *Id.* Case law may provide guiding principles. But those principles are "not exclusive" factors; they are intended to reach all relevant evidence. *Id.*

The Legislature, for example, imposes general duties of advocacy on guardians. The opening section of Chapter 11.88 RCW providing for appointment of guardians states the appointment of a guardian is intended to *protect* the liberty and autonomy of incapacitated persons. RCW 11.88.005. (App 1) The Legislature has also imposed duties generally on guardians to protect and maintain Constitutional rights. RCW 11.92.043(4). (App 2-3)

The Legislature recognizes that people with disabilities like Sandy and Rebecca need someone to speak for them because they cannot speak for themselves, and that the assistance of a Guardian is needed, to exercise rights and interests concerning their residence, health care, treatment, and services and to protect and maintain Constitutional rights.

Similarly, Standards of Practice of the Washington State Certified Professional Guardian Board (CPG Board) are promulgated under the auspices of the Washington Supreme Court. GR 23(c)(2)(ii). These Standards -- applicable to the Guardians in this case -- reiterate the need for assistance, advocacy, and the protection of Constitutional rights, and

how these typical guardian activities are effectuated under the supervision of the guardianship court.[7]

When a certified professional guardian is engaged in decision-making about any issue, a guardian refers not only to RCW 11.88.005, but to decision standards of the CPG Board. *CPG Board Standards of Practice 402, 402.1, 402.2.* (App 4) These standards describe a sliding scale of decision-making relative to the level of incapacity. This is easier said than done in most cases because human perception, understanding and action cannot be reduced to a simple graph. But generally speaking, as the degree of incapacity increases, the decision-making power of a guardian shifts from honoring preferences to protecting best interests. The decision-making standard is always applied in an individual case and based on the unique circumstances of the particular application of the standard, and not according to some "one size fits all" rule.

The degree of incapacity in this case is extremely profound. Sandy and Rebecca are unable to verbally articulate preferences because they are persons with no speech. The Guardians might be able to discern whether a reaction to an event is positive or negative, but when it comes to important future considerations like residential care, medical treatment, and services,

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[7] The "guardianship court" in this case is the Ex Parte Department of the King County Superior Court which hears guardianship cases for that court.

Sandy and Rebecca are not able to express preferences must less understand the consequence of any possible choices within the meaning of the SOPs. The best interests of Sandy and Rebecca are thus controlling in this case.

The Guardians have a recognized duty to protect generally the Constitutional rights residents of incapacitated persons, subject to the guardianship court's supervision. *CPG Board Standards of Practice* 400, 401. (App 4) One of these general and fundamental Constitutional rights of all citizens is the right to petition. Incapacitated persons including Sandy and Rebecca enjoy these rights. They may communicate and associate freely with others for political reasons. 42 C.F.R. § 483.420.[8] (App 8-9) In fact, those federal regulations *require the State* to "encourage individual clients to exercise their rights as clients of the facility [and] as citizens of the United States," 42 C.F.R. § 483.420(3), and to "ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail", 42 C.F.R. § 483.420(9), and to "ensure clients the opportunity to participate in social, religious, and community group activities, 42 C.F.R. § 483.420(11). The State's *opposition* to the exercise

[8] See, e.g., *Martyr v. Bachik,* 770 F.Supp. 1406 (D.Or. 1991) (preliminary injunction); *Martyr v. Mazur-Hart,* 789 F.Supp. 1081 (D.Or. 1992) (permanent injunction).

of residents' rights in this case is contrary to these federal rules, jeopardizes federal funding, and is reprehensible.

The Standards of Practice also impose the duty on the guardian to protect some specific Constitutional rights in specific contexts. Some examples: the right association must be protected in the context of residential decision-making, *CPG Standard of Practice 404.4* (App 5); the due process rights of persons in the care and custody of the State by exercising informed consent regarding care, treatment and services, *CPG Board Standard of Practice 405*[9] (App 5); and, the due process rights of persons in the care of the State to ensure the care, treatment and services is appropriate, *CPG Board Standard of Practice 405.1.*[10] (App 5) The Court may take judicial notice that the State asserts in the regular course of a guardianship case that these are rights to be exercised by guardians

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[9] E.g., *Zinermon v. Burch*, 494 U.S. 113 (1990), the Court held a hospital violated due process by admitting a non-objecting person who lacked capacity to consent to own his own admission.

[10] E.g., *Youngberg v. Romeo*, 457 U.S. 307 (1982), the Court held that an involuntarily held individual with "profound mental retardation" had a Constitutional interest in safe conditions of confinement, freedom from undue restraint, and minimally adequate treatment (known as "active treatment"), and a Constitutional right to adequate food, shelter, clothing, and medical care.

upon appointment.[11]

Constitutional rights are to be protected against infringement by third parties. This duty is an ethical one: "The guardian shall protect the incapacitated person's rights and best interests against infringement by third parties." *CPG Board Standard of Practice 403.8.* (App 5) The State is a third party and is opposing the rights of residents. The State also has physical custody of the incapacitated persons and is responsible for the care, treatment, and services provided. The State cannot be counted on to protect Sandy and Rebecca's Constitutional rights because those rights directly conflict with the State's fiscal or administrative interests *opposing* the residents' rights.

Where Sandy Lamb and Rebecca Robins live, and the nature and quality of the medical and other services they receive, are subject matters falling squarely within the duty of the Guardians. This duty to affirmatively protect (i.e., advocate) Sandy and Rebecca takes on heightened importance because of the unique facts in this case. As described in the Declarations filed by the Guardians, Sandy and Rebecca

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[11] See, e.g., Petition for Appointment of Successor Guardian, *In the Guardianship of Joshua Downing, Pierce County Superior Court No. 01-4-01782-1.* The Petition requested that a guardian "requires specific protection and assistance for: 1) the right to decide who should provide care and assistance and the right to consent to or refuse routing or emergency medical treatment; 2) The right to control the financial aspects of his life; 3) The right to decide matters relating to his residential placement and needs; 4) The right to manage his own health, medications and personal care."

are members of a unique class of persons with disability; DSHS and disability rights organizations are teamed together and threaten their best interests; the exercise of fundamental constitutional rights is in their best interests; and, there is no one else available to protect their rights and best interests.

The Court's order puts the Guardians in a pickle. On one hand, they have duties pursuant to those Standards and guardianship statutes. Guardianship duties attach regardless of the ability of Sandy and Rebecca to pay: "The duties of a guardian to an incapacitated person are not conditioned upon the person's ability to compensate the guardian." *CPG Standard of Practice 401.14.* (App 4) The Guardians are thus required to advocate for the best interests and Constitutional rights of Sandy and Rebecca. On the other hand, the Court has ordered them not to discharge those duties.

The superior court's decision is shocking to the best interests of Sandra and Rebecca. The superior court stripped rights to advocate before executive and legislative agencies from some of the most vulnerable people in the State by prohibiting all guardianship activities within the scope of the protection of Constitutional rights. This was not a decision based on equitable principles in a guardianship case, but a decision based on the untenable ground that access to the courts is enough.

In this case, the Guardians' advocacy activities are within the subject matter relating to residence, care, treatment and services of Sandy Lamb and Rebecca Robins. Because all of the Guardians' activities are limited to those subjects, their advocacy before legislative, executive, administrative and other community forums is proper. Modification of the guardianship to limit the Guardians' duties and powers can only occur if it is in the best interests of Sandy and Rebecca. See RCW 11.88.120(4). (App 10) Granting the Motion to Revise and reducing the guardian fee allowance to $ 75 per month was not in their best interests.

For the reasons above, this Court should reverse the superior court's order on revision and reinstate the Commissioner's Order. The Commissioner approved continued advocacy for residents, and approved a guardian fee allowance, based on the equitable factors discussed above, subject to demonstration at the time of the next guardians' report that those activities were within the scope of issues surrounding Sandy's and Rebecca's residence, care and treatment, also discussed above.

ISSUE 2: State Regulations, Including Chapter 388-79 WAC, are Pre-Empted by 42 U.S.C. § 1396p(a)(1) and (b)(1).

Summary of Argument. Because we are concerned here with Sandy's and Rebecca's best interests concerning their income vis-à-vis the State's interest in their income, a discussion of their income eligibility for

ICF/MR services, and federal and state estate recovery rules in the Medicaid context is necessary.

With federal Medicaid law as the backdrop, Section A below discusses "income eligibility" that qualifies them for ICF/MR services. Sandy and Rebecca are eligible to receive up to 300% of the SSI cash benefit standard. Alternatively, the social security disability benefits or railroad retirement benefits are not considered as income for eligibility purposes.[12]

Income eligibility is distinguished from the estate recovery described in Section B. There is nothing in federal Medicaid law that imposes or authorizes financial liability on Sandy and Rebecca to spend their income on their cost of care. Rather, states participating in the Medicaid program are prohibited from imposing liens or effectuating recovery or making adjustments prior to death (with exceptions not relevant in this case). Similarly, federal law does not impose any financial liability on recipients. Nor does it require States to in turn impose financial liability. Rather, those regulations require States to make a

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[12] Understanding the federal requirements of the Medicaid Act "present as complex a legislative mosaic as could possibly be conceived by man", *City of New York v. Richardson*, 473 F.2d 923, 926 (2nd Cir. 1973). Indeed, "clarity is recognized as totally absent from the Medicare and Medicare statutes", *Beverly Community Hospital Assn. v. Belshe,* 132 F.3d 1259, 1266 (9th Cir. 1997) cert denied 119 S.Ct. 334 (1998), and Medicaid statutes and regulations are "among the most completely impenetrable texts within human experience" constituting a "dense reading of the most tortuous kind", *Rehabilitation Ass'n of Va., Inc. v. Kozlowski,* 42 F.3d 1444, 1450 (4th Cir. 1994).

calculation after a recipient's eligibility is established prior to submitting the State's costs for federal matching funds.

Section C, below, reveals statute statutes, consistent with federal law, do not impose financial liability on Sandy's and Rebecca's income (with exceptions not relevant here). One series of statutory provisions permits recovery from "estates". A WAC extends the definition of "estate" far beyond the federal definition and falsely references a statute having nothing to do with financial liability as authority for its promulgation. Resident trust accounts may be liable for reimbursement for cost of care under another statute. *But that liability ceases upon the appointment of a guardian.* Remarkably, under the circumstances of this case, there is no valid state law authority that expressly imposes financial liability on Sandy and Rebecca to spend their income to the State.

Section A. Sandra's and Rebecca's Income Eligibility and Treatment under Federal Statutes and Regulations.

Medicaid was enacted in 1965 as Title XIX of the Social Security Act, 42 U.S.C. secs. 1396 et seq. Initially, cash assistance was provided under Title I (Old Age), Title X (Blind), Title XIV (Disabled) and Title IV-A (Aid to Families with Dependent Children), and medical assistance under Medicaid accompanied that cash assistance. These groups were considered categorically needy (CN). The Social Security Act

Amendments of 1972 replaced cash assistance for those groups with the Supplemental Security Income (SSI) program, and redefined Medicaid eligibility by referencing SSI medical and financial eligibility. 42 U.S.C. § 1396a; 42 CFR §§ 435 et seq.

The usual SSI income standard is $ 1,752.00 per year or $ 145.00 per month. 42 U.S.C. § 1382(a)(1)(A) (App 40). The SSI reduced income standard for a resident of an ICF/MR (other facilities are not relevant here) is $ 360.00 per year or $ 30.00 per month. 42 U.S.C. § 1382(e)(1)(B)(i) (App 45).

All aged, blind, and disabled persons receiving or deemed to be receiving SSI benefits are considered CN. 42 U.S.C. § 1396a(a)(10)(A) (App 21-25); 42 C.F.R. § 435.120. (App.) The mandatory CN group is set forth in 42 U.S.C. § 1396a(a)(10)(A)(i) (App 21-22). Optional CN groups are set forth in 42 U.S.C. § 1396a(a)(10)(A)(ii) (App 22-25) There are two optional CN groups under the State Medicaid Plan. First, residents of ICF/MR who would be eligible for cash assistance[13] if he or she was not residing in an ICF/MR, 42 U.S.C. § 1396a(a)(10)(A)(ii)(IV)

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[13] It is important at this point to understand the distinction between the cash benefits received from social security disability and railroad retirement from the cash benefits received under SSI. Sandy and Rebecca do not receive cash benefits under the SSI program. They qualify for Medicaid using the income eligibility standards in SSI, and those income eligibility standards refer to cash benefit amounts tied to the SSI program. When cash benefits are referred to here, they are standards under the SSI program.

(App 23); 42 C.F.R. 435.211 (App 48B) ; *State Medicaid Plan*, Attachment 2.2-A, Page 9c (Paragraph B(2)) (App 48C) ; and, second, residents of ICF/MR who would not be eligible for SSI cash assistance because of the reduced income standard and whose income does not exceed more than 300% of the maximum SSI benefit, 42 U.S.C. § 1396a(a)(10)(A)(ii)(V) (App 23); 42 C.F.R. § 435.236 (App 48D); *State Medicaid Plan*, Attachment 2.2-A, Page 19 (Paragraph B(12)) (App 48E-).

Sandy and Rebecca may be eligible under other optional CN groups, but fall squarely within the CN optional group described by 42 C.F.R. § 435.236 and State Medicaid Plan. The consequence is that they may earn up to 300% of the maximum SSI benefit and remain eligible.

The SSI payment standard for a single individual is $ 674.00.[14] 300% of that figure is $ 2,022.00 per month. Sandy and Rebecca each have income less than $ 2,022 per month. Based on 2008 income received, Sandy's income and Rebecca's income on a monthly basis is much lower. CP 22, 111. Pursuant to 42 C.F.R. § 435.236, they may have income up to $ 2,022.00 per month and their financial eligibility is not affected. (Though this is called an "income cap" it allows income up to a ceiling.) In addition to income eligibility, residents must also be resource

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[14] Social Security Online, "Automatic Increases, SSI Federal Payment Amounts" at http://www.ssa.gov/OACT/COLA/SSI.html, accessed February 21, 2009 (App. 46).

eligible each month. It is not in dispute that the SSI resource limit is $ 2,000.00 in any given month. There is no need to do any further calculations for establishing *income or resource eligibility.* Sandra and Rebecca are clearly eligible.

The foregoing assumes that all of Sandy's and Rebecca's income is counted as income under SSI financial eligibility rules. However, that is not the case. Regardless of the income eligibility standard applied, at the threshold level income must be countable, i.e., it is either income or it is not income. For example, the most restrictive income standard is the statutory entitlement to a cash benefit of $ 360.00 per year or $ 30.00 per month described earlier. Countable income is deducted from the benefit dollar for dollar and the balance is the cash payment a resident is entitled to receive. 20 C.F.R. § 416.420 (App 47-48). If Sandy and Rebecca have income in excess of the statutory benefit amount, they are rendered ineligible. 20 C.F.R. § 416.1100 (App 78). Monthly countable income is calculated by evaluating it and determining first, and in relevant part, whether it is considered income or "not income". 20 C.F.R. § 416.1103 (App 79-81). Sandy's social security disability income and Rebecca's railroad retirement income are considered unearned income. 42 U.S.C. § 1382a(a)(2)(B) (App 72). Wages obtained by either in sheltered workshops is earned income. 42 U.S.C. § 1382a(a)(1)(C) (App. 71).

However, income must be "actually available" to be counted as income in the first place. If it is not actually available, it is not income. There are three relevant categories that make Sandra's and Rebecca's income "not available".

First, income that cannot be expended to obtain food and shelter is not income. 20 C.F.R. § 416.1103 (App 79-81). In this case, the income is deposited into the resident trust fund at Fircrest. The funds cannot as a matter of state law expended for any Medicaid services under Title XIX. WAC 388-835-0350 (App 83). It is not in dispute that ICF/MR services at Fircrest School include food and shelter. Since the funds cannot be paid for food and shelter at Fircrest, the funds therefore are not available income.[15] The fact they are not paid to the State in no fashion diminishes the services the State is required to provide.

Second, the provision of guardian services is a loan of services. The trial court pre-authorized the service as well as the payment of guardian fees prior to the receipt of any monthly income. Sandy and Rebecca are thus required to pay off that loan. 20 C.F.R. § 416.1103(f) (App 80). The monthly guardian fee allowance and approval and payment of fees in the ordinary course means the income is not available to Sandy

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[15] Residents can, however, use income to pay for state provided meals at the cafeteria or go off-campus to pay for meals. DSHS does not pay for cafeteria items or for off campus meals.

and Rebecca. Typical court orders awarding guardian fees say so.

Finally, the provision of guardianship services is in-kind assistance an individual receives pursuant to a government social services program. 20 C.F.R. § 416.1103(b) (App 79-80). As certified professional guardians, the Guardians in this case provide social services in a legal context as set forth in the CPG Standards of Practice and under the auspices of an agency created by the Washington Supreme Court.

Regardless of the income eligibility standard applies, payments for guardianship fees for residents of ICF/MR are considered "not available" to Sandy or Rebecca when determining their income eligibility.

Income eligibility for the medically needy (MN) is the same as the optional CN but arises in circumstances that are not relevant here. Persons in the MN group are those who would otherwise qualify for (in relevant part) ICF/MR services, have excess income or resources, and who have incurred medical expenses he or she cannot pay. 42 C.F.R. 435.301(a)(1)(ii) (App 84-85). The same SSI income eligibility rules applied for CN groups are applied for MN groups. 42 C.F.R. § 435.831(b)(2) (App 86). MN income eligibility rules cannot be more restrictive than CN rules. 42 U.S.C. § 1396a(a)(10)(C), (17), (r)(2). (App 25, 30-31, 35).

The purpose of the MN program is to allow an individual to "spend down" income and resources by paying medical expenses, regardless of reimbursement under other programs. 42 U.S.C. § 1396a(a)(17)(D) (App 30-31). States have the option of allowing the individual to pay the "spend down" amount to the State for medical expenses so that the individual does not incur medical expenses. 42 U.S.C. § 1396b(f)(2)(B). In this case, however, there are no income or excess resources to "spend down". The MN "spend down" rules do not apply here.

The Guardians do not claim that MN rules do not apply in every case. Indeed, those rules seem to apply if income is accumulated and exceeds the resource limitation of $ 2,000.00. In such a case, the amount of resources is in excess of resource eligibility standards and may be subject to MN "spend down" rules.

In conclusion, under Medicaid law, Sandy and Robin are income eligible for continued residence at ICF/MR. Calculating income eligibility is performed by determining the applicable income eligibility standards in the SSI program. Regardless of the income eligibility standard, however, money expended for guardian fees is considered as not available to them.

Section B. Federal Medicaid Law Prohibits Liens, Adjustments, and Recoveries from Sandy's and Rebecca's Income.

i. The Legal Framework. The Medicaid program is a jointly

funded cooperative venture between the federal government and the states. 42 U.S.C. § 1396. Acting within broad federal guidelines, each state establishes its own eligibility groups; decides on the types, range, amount and duration of services; determines its own administrative and operating procedures; and, decides payment levels for services rendered by providers. 42 C.F.R. § 430. Many details of each state's Medicaid program are described in the state's Medicaid Plan. The program is administered at the federal level by the Center for Medicare and Medicaid Services (CMS) (formerly known as Health Care Financing Administration or HCFA). Federal regulations are codified at 42 C.F.R. Parts 430-456. The State Medicaid Manual published by CMS provides informal administrative guidance. States also implement the Medicaid program with legislation and administrative regulations.[16]

ii. Federal Law is Construed to Effectuate Sandy's and Rebecca's Best Interests. This Court should construe federal statutes so that the administration of the program is in the "best interests" of the recipient because the State is duty-bound to administer the Medicaid program for

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[16] See generally Chapters 74.04, 74.08, and 74.09 RCW. Issue 2 relies predominantly on federal law, and state law must conform, citation to state statutes and regulations are not usually necessary. The provisions of Title 74 are to be administered to conform to federal requirements with respect to the receipt of federal grants or funds. RCW 74.05.050. Any ambiguity is interpreted by the Court in favor of a construction that most likely to satisfy *federal laws* regarding the receipt of federal funds. RCW 74.05.055. In the event of conflict between a provision of chapter 74.05 and federal requirements, state law is inoperative to the extent of the conflict. RCW 75.05.055.

that purpose. Each State must administer the Medicaid program in the "best interests of the recipients." 42 U.S.C. § 1396a(a)(19) (App 31). The Act and its implementing regulations must be construed liberally in favor of the Medicaid recipient. *Cristy v. Ibarra*, 826 P.2d 361 (Colo. Ct. App. 1981) (App 60-63).

iii. Federal Law Does Not Impose Financial Liability[17] on Sandy and Rebecca.

The federal lien and recovery statute (42 U.S.C. § 1396p) (App 150-164) imposes a comprehensive and exhaustive scheme of limitations on States to impose liens and to collect or recover for Title XIX services provided by the State. Under limited circumstances, States may impose liens and may make "adjustment or recovery" to recover costs expended for Title XIX medical assistance. 42 U.S.C. § 1396p(a) (liens); 42 U.S.C. § 1396p(b) ("adjustment or recovery"). The limitations in 1396p are express, in terms of general prohibition with limited exceptions.[18]

No lien may be imposed on "property" (i.e., real or personal

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[17] The term "participation" or the phrase "participation in cost of care" is avoided to avoid confusion because of other Medicaid regulations that discuss participation of providers in the Medicaid program; participation by the State in the Medicaid program; and federal financial participation in the Medicaid program. Imposing "financial liability" is also a more accurate term to the extent a Medicaid recipient, in this case an ICF/MR resident(s), is required to apply his or her social security benefit to pay towards his cost of care.

[18] The burden of proof generally rests with the party claiming the benefit of an exception. *NLRB v. Kentucky River Community Care, Inc.*, 532 U.S. 706, 121 S.Ct. 1861, 149 L.Ed. 2d 939 (2001).

property, or choses in action) prior to death. The relevant exception permits imposition of a lien on real property prior to death. A condition precedent for that exception is a case where an individual is required as condition to receiving services to spend funds for his or her cost of care. There is no requirement in 1396p, however, requiring States to impose the requirement on individuals to spend for their own cost of care, and there is no requirement in 1396p imposing the requirement directly on individuals.

The State is prohibited from making any adjustment or recovery from the property of an individual until death, and then it may do so only from the probate estate of the individual. 1396p(b)(1) imposes similar prohibitions on adjustments and recoveries. There is a general prohibition against adjustments and recoveries against property. 42 U.S.C. § 1396p(b)(1). The relevant exception limits recoveries to estates. 42 U.S.C. § 1396p(b)(1)(B). "Estate" is defined as a probate estate. 42 U.S.C. 1396p(b)(4) (App 152). 1396p(b)(1) is also clear. Sandra and Rebecca are still living. The exception does not apply The State in this case cannot adjust or recover against the income of Sandy or Rebecca.

Implementing regulations support this interpretation of the exception. "[T]he agency may place a lien against the real property of an individual at any age before his or her death" when (a) the individual is an "inpatient of a medical institution and must . . . apply his or her income to

the cost of care as provided in secs. 435.725, 435.832 and 436.832" and (b) the individual is institutionalized and not expected to return home. 42 C.F.R. § 433.36(g)(2) (App 165-166). The phrase "must . . . apply his or her income to the cost of care as provided in [the cited regulations]" cannot be read outside the context of the exception to which it applies: like 1396p(a) and 1396(p), 42 C.F.R. § 435.725 (App 167-169) applies only when a State imposes financial liability in conjunction with imposing a real estate lien prior to death.

Similarly, 42 C.F.R. § 435.725 does not impose financial liability on individuals because its purpose is to impose a limitation on *States*, not on individuals. 42 C.F.R. § 435.725 requires the State to reduce *its* payments for ICF/MR services by the amount of financial liability imposed on the individual when a lien is imposed prior to death pursuant to 1396p. The calculation under this regulation is solely to ensure the correct amount of federal matching funds. States are thus prohibited from claiming FFP on the total cost of monthly care, getting FFP, and then collecting again from the recipient to reduce expenditure of State funds already matched. The purpose of 42 C.F.R. § 435.725 is to require States to reduce its payments by the amount of State financial liability imposed and seek FFP only on the reduced amount. *James on behalf of State of Alabama v. Harris*, 499 F.Supp. 594 (M.D.Ala.1980), *aff'd* 650 F.2d 814

(5th Cir. 1980) (App 170-174).

Furthermore, 42 C.F.R. § 435.725 does not concern eligibility or threaten a loss of eligibility. Rather it concerns a post-eligibility calculation and assumes the individual is already eligible as one of the classes of individuals under 42 C.F.R. § 435.725(b). For example, income disregarded in "determining eligibility" is considered in the calculation, 42 C.F.R. § 435.725(c), indicating what we already know, that income eligibility is determined under SSI rules, not by this regulation. The deduction for calculating FFP should not be confused with treatment of income for establishing eligibility discussed earlier in this Brief.

In conclusion, the federal Medicaid estate recovery statutes and the related regulations cited above do not impose financial liability on the residents in this case. Far from creating any financial liability, Sections 1396p(a) and/or 1396p(b) prohibit liens or encumbrances by the State on the property of the residents. *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed 2d 459 (2006). State statutes and regulations which are in conflict and inconsistent are inoperative. *Id.* (App 175-191).

Section C. State Statutes and Regulations Imposing Financial Liability are Inoperative to the Extent they are Inconsistent.

State statutes address imposing financial liability and recovering

for cost of care for residents of ICF/MR. There are two sets of relevant statutes in Title 43.20B and in Title 71A. These statutes do not apply to Sandra and Rebecca. RCW 43.20B.410 et seq expressly limit imposition of financial liability to the "estates" of residents of ICF/MR. RCW 71A.20.100 does authorizes disbursements from a resident trust account for reimbursement for cost of care, but that authority terminates when a guardian is appointed. That statute also does not apply to Sandy and Rebecca.

First, the purpose of RCW 43.20B.410 through RCW 43.20B.455 (App 200-212) is to impose financial liability for the cost of care on residents of ICF/MR. However, like (and consistent with 1396p) these statutes impose liability only on "estates" of residents of ICF/MR. Again, only "estates" are liable for cost of care. RCW 43.20B.415. There is a process for serving a notice of finding of financial responsibility. RCW 43.20B.430. The recovery is limited to prospective care; reimbursements for cost of care are *not* allowed. RCW 43.20B.440. Because Sandra and Rebecca are still living, these statutes do not impose financial liability and do not apply to them.[19]

Second, resident trust accounts may be liable for reimbursement

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[19] In any event, there is nothing in the trial court record showing compliance with these statutes.

for cost of care under the limited circumstances set forth in RCW 71A.20.100 (App 213). The statute in relevant part authorizes the Secretary to make disbursements for reimbursement for cost of care to the extent a process is followed for a notice of and finding of financial responsibility.[20] RCW 71A.20.100. However, once a guardian is appointed and DSHS has letters of guardianship on file, the Secretary's authority to make these disbursements under state law terminates. *Id.*

These statutes do not apply to this case. There is no other known relevant statute requiring residents of ICF/MR to spend from their trust account or authorizes DSHS to impose financial liability. Assuming without agreeing there is such a statute or regulation, it would be limited in operative effect by 1396p.

WAC 388-835-0925 to 835-0955 (App 214-220) appears to impose financial liability on residents of ICF/MR. They in turn rely on RCW 71A.20.140 (App 221) as authority for their adoption. However, RCW 71A.20.140 is not relevant at all, at the reference to statutory authority is false. *Compare* RCW 71A.20.140 (authorizing the Secretary to hold residents for a limited time) with WAC 388-835-0940(1) (App 218) (extending the definition of "estate"). These regulations are not valid

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[20] Again, there is nothing in the record to show compliance with this statute.

because they are premised on a false statement of statutory authority.

Assuming without agreeing the regulation is otherwise valid, this WAC is inoperative because it is inconsistent with 1396p(b)(1) limitation on adjustments and recovery to estates and far outside the scope of the federal definition of "estate" in 42 U.S.C. § 1396p(b)(4) (App 152). These WAC provisions therefore do not apply to Sandy and Rebecca because they are still living.

Second, and similarly, Chapter 388-79 WAC (App 222-224) does not apply to Sandy and Rebecca because it is inoperative. It is based on a mistaken premise that federal law authorizes Sandy and Rebecca to spend for their cost of care as a condition of receiving ICF/MR services. WAC 388-79-010; WAC 388-79-050(4)(b)(i). But there is no financial liability imposed under federal law and no federal regulations limits deductions except in the context of calculating FFP. 388-79 conflicts with 1396p and is inoperative.[21]

Other relevant statutes manifest a strong public policy against recovery from resident trust accounts. Federal law prohibits commingling of resident trust funds with that of the State. 42 C.F.R. §483.420(b)(1)(ii).

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[21] Chapter 388-79 WAC and WAC remain operative to the extent that the State imposes liens on real estate of ICF/MR residents while they are living or imposes recovery on estates. Similarly, WAC 388-835-0925 to 835-0955 remains operative to the extent it applies to probate estates.

(App 9). State law makes it a criminal offense to improperly handle patient trust accounts. RCW 74.09.270. (App 225) RCW 74.09.260 prohibits excess charges. (App 226). State regulations plainly say "resident trust accounts cannot be charged for services provided under Title XVI." WAC 388-835-0350 (App 83). There are no exceptions.

Section D. ALTERNATIVELY, Advocacy Services are "Extraordinary" within the Meaning of Chapter 388-79 WAC.

Assuming without agreeing that Chapter 388-79 WAC and WAC 388-835-0925 to 835-0955 are operative, advocacy activities in this case are "extraordinary". WAC 388-79-010. None of the definitions in WAC 388-79-020 are in dispute.

There is no dispute that the Guardians rendered advocacy services on behalf of Sandra Lamb and Rebecca Robins. WAC 388-79-030 limits the amount of fees in court orders unless otherwise modified by the procedures in WAC 388-79-040. In relevant part, the amount of guardianship fees approved shall not exceed $ 175.00 per month unless increased by the court. WAC 388-79-030. The procedure in WAC 388-79-040 refers only to the period through August 31, 2003. On and after September 1, 2003, WAC 388-79-050 applies. If the fees are $ 175.00 or less, the State does not count the $ 175.00 as available income. If the fees are more than $ 175.00, notice must be given, and DSHS considers

various factors to determine whether or not the State will count the requested fee as available income. WAC 388-79-050(4). The only relevant factor here is whether or not guardianship activities constitute "extraordinary services." WAC 388-79-050(4)(b)(iii).

"Extraordinary services" include unusually complicated property transactions; substantial interactions with adult protective services or criminal justice agencies; extensive medical services setup needs and/or emergency hospitalizations; and, litigation other than litigating an award of guardianship fees or costs. WAC 388-79-050(4)(b)(iii)(A)-(D). The court, however, makes the final decision on whether or not income is deemed available for purposes of contributions to cost of care. WAC 388-79-050(4)(c). Other provisions not mentioned are not relevant here.

In summary, the WACs recognize a guardian's authority to engage in extraordinary service, the Court's authority to approve fees for such services, and the Court's authority to order payment for such services from an incapacitated person's income.

The interpretation of the phrase "extraordinary services" is at issue. The Court interpreted WAC 388-79-050(4)(b)(iii) as not including advocacy activities directed at legislative, executive, administrative agencies, and local governments. The phrase "such as" clearly indicates the examples are not exclusive. A principle of statutory construction

applicable here is that of *noscitur a sociis*, which provides th single word in a statute should not be read in isolation, and that "the meaning of words may be indicated or controlled by those with which they are associated." *State v. Jackson*, 137 Wn.2d 712, 729, 976 P.2d 1229 (1999). The pattern or common theme emerging from the four examples given demonstrates that advocacy services fit within the scope of the term "extraordinary services." Generally, WAC 388-79-050(4)(b)(iii)(A), (B), (C), and (D) all refer to "complicated", "substantial", or "extensive" subject matter which require and intensive use of time by a guardian. WAC 388-79-050(4)(b)(iii)(C) and WAC 388-79-050(4)(b)(iii)(D) both contemplate interactions with executive or administrative agencies or the courts on behalf of an incapacitated person. The advocacy services in this case as laid out on the record affect Sandra Lamb and Rebecca Robins and are directly related to the residence, the care, treatment, and services provided to them. There is no indication on the record of any advocacy service provided which is not related to that subject matter.

In conclusion, the advocacy services are compensable as "extraordinary services" contemplated by WAC 388-79-050(4)(b)(iii) and WAC 388-79-050(4)(c) based on the facts and law in the case.

Section E. ALTERNATIVELY, the WACs and Statutes Unconstitutionally Abridge the Equity Discretion of the Court.

The Legislature has enacted two relevant statutes relating to guardian fees in guardianship cases. RCW 11.92.180 (App 300); RCW 43.20B.460 (App 212). In addition, the State has promulgated Chapter 388-79 (App 222-224).

RCW 11.92.180 and RCW 43.20B.460 purports to permit DSHS to dictate a cap on fees to the courts. Chapter 388-79 has already been discussed. These statutes and rules are inoperative because they constitute an unconstitutional abridgement of the powers of a guardianship court to determine guardianship matters.

Compensation of guardians is a matter within the sole province of the superior court. Guardianships cases are within the original jurisdiction of the superior court. Wash. const., Art. IV, § 6. The power to administer a guardianship case falls within the general equity powers of the superior court, and such power is cumulative and concurrent with the powers exercised by the English court of chancery. *Guardianship of Sall*, 59 Wash. 539, 542-43, 110 P. 32 (1910). Such equity jurisdiction is based on that part of Art. IV, § 6 which vests jurisdiction in the superior court for "such special cases and proceedings as are not otherwise provided for." *Id.*, at 546. *In the Matter of Guardianship of Adamec*, 100 Wn.2d 166, 667 P.2d 1085 (1983). The allowance of fees is part and parcel of the administration of a guardianship case in equity. See *Guardianship of*

Spiecker, 69 Wn.2d 32, 416 P.2d 465 (1966); *Guardianship of Kelly*, 193 Wash. 109, 74 P.2d 904 (1938) (allowance of fees discretionary with the court).

The State consistently argued below that federal matching funds were a source of guardian fees. False. The State consistently argued below they were state funds earning interest in the State treasury. Also false. In fact, Sandy's social security benefits and Rebecca's railroad retirement benefits are paid to Fircrest School as representative payee or federal fiduciary appointed under federal law. Fircrest School is the representative payee appointed by the Social Security Administration on behalf of Sandra and Rebecca pursuant to 42 U.S.C. § § 201-234 (Sections 401-434 of the Social Security Act) (Title II) (Old Age, Survivors, and Disability Insurance).[22]

There is no federal court jurisdiction. There is no federal law pre-emption of the court's jurisdiction in the field. The Social Security Administration has concurrent jurisdiction. Removal of the representative payee or suspension of payment of social security benefits to a payee is within the jurisdiction of the SSA. See generally 42 U.S.C. § 405(j) (App

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[22] The record is not developed with respect to Rebecca's railroad retirement benefits. Discussion here is limited to Sandy's social security benefits. It is assumed by the Guardians that substantially similar rules apply to fiduciaries for railroad retirement benefits.

301-312). No such relief is sought in this case. And disputes between the representative payee and the beneficiary of public benefits is not covered by 405(j). The guardianship court has concurrent jurisdiction to determine Sandy's and Rebecca's best interests in the context of a guardian's advocacy activities and the fees incurred as result.

Nor is the exercise of superior court jurisdiction barred by the so-called Anti-Alienation provision of the Social Security Act, 42 U.S.C. 407 (App 313-314), which protects social security beneficiaries against claimants and creditors. The superior court's orders regarding the use of social security benefits are not in the nature of action or legal process at the instance of a claimant or a creditor against the beneficiary. Section 407(a) of the Act does not bar the use of court orders directed to the State as representative payee concerning the use of a beneficiary's monthly social security benefits.

Guardianship statutes are codified in Chapters 11.88 and 11.92 RCW. Guardianship statutes "are only declaratory of the power already and always possessed by courts of chancery, and they will even now exercise that power concurrently or in aid of a statute." *Weber v. Doust,* 84 Wash. 330, 333-34, 146 Pac. 623 (1915). The Legislature has enacted declaratory statutes regarding the scope of the jurisdiction of the court, recognizing that in cases of doubt, the court still exercises its jurisdiction.

RCW 11.96A.020 (App 315). The Legislature has also declared the original subject matter jurisdiction of the Court to include guardianship matters and includes anything necessary and proper to carry that jurisdiction into effect. RCW 11.96A.040 (App 316). Finally, the court may use all types of orders or legal process to exercise of its jurisdiction. RCW 11.96A.060 (App 317). Ending all doubt is a statute specifically authorizing the court exercise discretion to apply funds "not required for the incapacitated person's own maintenance and support". RCW 11.92.140 (App 318-319).

There is no threat to the continuing Medicaid eligibility of Sandra or Rebecca as discussed earlier. There is no other interest paramount to the court's exercise of jurisdiction to protect their best interests. These statutes declaratory of the common law recognize and confirm the Court's jurisdiction.

RCW 11.92.010 (App 320) provides, "Guardians or limited guardians herein provided for shall at all times be under the general direction and control of the court making the appointment . . . ." A guardian is responsible to his or her court of appointment. *In re Gaddis' Guardianship*, 12 Wn.2d 114, 120 P.2d 849 (1942). The court has the ultimate say on how the best interests of an incapacitated person are served by guardians.

A statute will be declared unconstitutional in the event that the Legislature abridges the equity powers of the superior court. *Blanchard v. Golden Age Brewing Co.*, 188 Wash. 396, 63 P.2d 397 (1936). No other branch of government may abolish or abridge the jurisdiction of the superior court to exercise a power in equity, or require an alternate process in such a way as to abolish or abridge the power. *Id.* If that occurs, there is an unconstitutional encroachment on the judicial power.

RCW 11.92.180 is not merely declaratory of the equity powers of the superior court. It abridges the court's power. Most of RCW 11.92.180 is declaratory or procedural, but the provision also says the court may not award guardian fees or attorney fees over the limits imposed by rule. Similarly, RCW 43.20B.460 authorizes the State to establish by rule the maximum amount that may be allowed by the guardianship court. Reading the two statutes together, DSHS is delegated the authority to set maximum fee amounts for the courts. Chapter 388-79 implements these statutes.

It is an exclusive function of the guardianship court to review and approve the payment of guardian fees generally. These two statutes and Chapter 388-79 are inoperative to the extent (a) they authorize another agency to set compensation of guardians, (b) implement such an authorization by establishing an administrative approval procedure, and (c) deprive the court of concurrent jurisdiction to determine order a

representative payee to make payments effectuating the best interests of an incapacitated person and determine that such income is not available. None of these powers exercised by the court affect the eligibility or the process of calculating the federal match. DSHS has taken on the court's role of regulating, reviewing and approving guardian fees, and the court's role for determining what is in the best interests of Sandy and Rebecca, abridging the power of the court, and such a role is impermissible under our Constitution.

Issue 3: Violation of Art. I, § 4 of the Washington Constitution and the First and 14th Amendments of the United States Constitution.

A. Violation of the Right to Petition by Prior Restraint.

1. Violation of The Right to Petition.

Every person has fundamental right to petition the government. The fundamental right in the First Amendment applies through the Due Process Clause of the Fourteenth Amendment. The right to lobby legislators and executive branch and administrative officials is contemplated within this right. *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 510 (1972). The very purpose of a guardianship is to exercise the rights and interests of another so long as it is in the best interests of the other. The Court has ruled that the lobbying of legislators and executive branch officials is outside the scope of

guardianship. It follows that the Guardian is prohibited from exercising the right to petition on behalf of Sandra Lamb and Rebecca Robins. Their right to petition has been wholly deprived by the Court's order.

2. The Court's Order is a Prior Restraint on the Exercise of the Right to Petition.

The Court's order represents a prior restraint on the exercise of the right to petition. Because Sandra Lamb and Rebecca Robins cannot speak through their Guardians, the Court's order has the effect of a restraint prior to the exercise of the right to access to the legislative, executive or administrative branches of government is forever barred. The plain use of the word "never" in Wash. const. Art. I, § 4 indicate that prior restraint of the right to petition is strictly prohibited, or is subject to heightened court scrutiny. *Ino Ino Inc. v. Bellevue*, 132 Wn.2d 103, 117, 937 P.2d 154 (1997) (as to Art. I, § 5).

B. Effect of the Exercise of the Right: DSHS Lacks a Countervailing State Interest.

1. DSHS Lacks Standing.

DSHS lacks standing to object to the exercise of fundamental rights, including the right to petition, by the Sandra Lamb and Rebecca Robins. 42 C.F.R. § 483.420.

DSHS' interest in precluding advocacy services which involves the

residence, and the care, treatment and service that DSHS itself provides poses an incredible conflict of interest. It can cite no injury in fact arising from such advocacy activities caused by the Guardians which can be redressed by denying the right to petition. It can cite no statutory or regulatory basis for its interest in doing so.

2. The DSHS Interest in Silencing Fircrest Residents is Not Sufficient to Confer Standing.

There is absolutely no interest of the State affected by the Guardian's contact and discussion of these subjects with legislators and officials on their behalf, and no such a right or interest is paramount to the best interests of Sandra Lamb and Rebecca Robins. None of these rights or interests conferred by statute and/or cited by DSHS expressly or impliedly limits the exercise of the right to petition in this manner. Since the State lacks any interest in opposing the exercise of the advocacy services by Guardians of Fircrest School, the right to petition must prevail.

3. Any DSHS Interest is Already Adequately Protected.

Assuming (without agreeing) that DSHS has a cognizable interest at all, such an interest is adequately protected by means other than precluding the Guardians' advocacy activities. DSHS has notice and the right to be heard regarding the award of guardianship fees. RCW 11.92.180; RCW 43.20B.460. DSHS can challenge the cost of advocacy

activities in the event they are not directly related to the residence, care, treatment, and services of Sandra Lamb and Rebecca Robins and therefore not in their best interests. In addition, DSHS may petition the guardianship court to modify the guardianship in the best interests of an incapacitated person. RCW 11.88.120(1), (2), (4). (App 10) The interests asserted by DSHS are already adequately protected by these statutes. None of them provide a basis for limiting the exercise of the right to petition. Since the interests of DSHS are already adequately protected, the right to petition must prevail. The Order entered by the superior court is not narrowly tailored to accomplish a legitimate State purpose.

C. The Scope of the Right.

The exercise of the right to petition through their Guardians concerning the residence, care, treatment, and services Sandra Lamb and Rebecca Robins receive is fundamental and far outweighs any countervailing interest DSHS possesses. Funding for their residence, care, treatment and services are all budget dependent. Political will is necessary to influence and ensure services are adequate, and having an affect on that will requires contact with the legislative branch, the executive branch, local government, and administrative agencies including DSHS.

1. Art. I, § 4 of the Washington Constitution Provides Greater Protection than the United States Constitution.

The Washington Constitution provides greater support than the parallel First Amendment of the United States Constitution when it comes to the exercise of the fundamental right to petition the legislative, executive and administrative agencies and local governments. Such additional protection is provided according to the non exclusive, neutral criteria contained in *State v. Gunwall*, 106 Wn.2d 54, 58, 720 P.2d 808, 76 A.L.R.4th 517 (1986) and as set forth below. See also *State v. Reece*, 110 Wn.2d 766, 777-78, 757 P.2d 947 (1988) (stating that the proper inquiry under *Gunwall* is whether "on a given subject matter" the Washington constitutional provision should give greater protection than the minimum protection afforded by the federal constitution), *cert. denied*, 493 U.S. 812 (1989).

(1) The Textual Language.

Art. I, § 4 provides, "The right of petition and of the people peaceably to assemble for the common good shall never be abridged." The First Amendment states, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances." The textual language declares the right of petition shall never be abridged, which is similar to that in the First Amendment.

(2) Textual Differences.

This provision is textually separate in Washington Constitution from access to the courts and freedom of speech provisions, indicating an independent reliance or analysis for each provision. The right to petition is qualified in that the exercise of the right must be for the "public good." The text in the Washington Constitution uses the word "never", which is not included in the First Amendment.

(3) Constitutional and Common Law History.

The right of petition has its beginnings with the Magna Carta in 1215. Procedures for petitioning the Parliament, the Lord Chancellor in equity cases, and the "petition of right" proceeding against the Crown are all founded on the right of petition. In 1669, the House of Commons resolved that there was an inherent right of every commoner to prepare and present petitions, and for the Commons to receive it. The Bill of Rights of 1689 asserted a right to petition the King. Historically, the right to petition is the primary one, and the right of assembly secondary. The case of *United States v. Cruikshank*, 92 U.S. 542 (1876) (App.) reflects the view that the right to peaceable assemble is for the purpose of petitioning the government. See generally *The Constitution of the United States of America, Analysis and Interpretation,* Congressional Research Service, Library of Congress, 1267-71 (2004). This view helped inform the

adoption of this provision in the Washington Constitution in 1889. Since that time, it is understood that the right to petition extends to "all departments of the Government", including administrative agencies, and not merely access to the courts. *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 510 (1972). (App)

(4) Pre-existing State Law.

The right to petition is so fundamental that there is no known pre-existing state law prior to statehood that supports the existence of the right or limitations of the right.

The interpretation by a high state court of a similar provision borrowed from another state prior to statehood may inform the nature and extent of the right.

(5) Differences in Structure between the Federal and State Constitutions.

This factor always favors an independent state interpretation. *State v. Russell*, 125 Wn.2d 24, 61, 882 P.2d 747 (1994), cert. denied, 115 S.Ct. 2004, 131 L. Ed. 2d 1005 (1995). The federal Constitution is a delegation of limited, enumerated powers, while the state Constitution is one of limitation of state governmental powers.

The Constitutional purpose is the protection and maintenance of individual rights, Wash. Const. art. I, § 1. The United States Constitution

contains no such parallel provision.

(6) Matters of Particular State or Local Concern.

The exercise of a right to petition by persons with disability through their guardian is more uniquely a state and local interest than it is a federal concern. Guardianship cases typically concern the inherent equity jurisdiction of state courts and each state has different law concerning the administration of guardianships and the rights of disabled individuals. In this case, the State is also under a constitutional duty to support and foster institutions for the developmentally disabled of which Sandra Lamb and Rebecca Robins are residents. Wash. Const., art. XIII.

2. The Significance of the Right.

The significance of the right is influenced by the many factors, including but not limited to those set forth in the the *Guardians' Response to DSHS Motion for Revision*, at 6-7, and *Guardians' Response to DSHS Objection*, at 4-5. In summary, Sandy and Rebecca are members of a unique class of persons with profound disabilities; DSHS and disability rights organizations oppose their interests; the exercise of fundamental constitutional rights is in their best interests; and, there is no one else available to protect their rights and interests. Advocacy activities closely aligned with their residence, care, treatment and services -- matters clearly related to their most significant interest -- should not be precluded or

limited primarily because they cannot speak for themselves and are in the custody of DSHS.

Residents in state custody retain their constitutional rights. *Youngberg v. Romeo*, 457 U.S. 307 (1982). Those rights include a right to communicate with public officials. *Wyatt v. Stickney*, 344 F.Supp. 373, 379 (M.D.Ala. 1972). (App)

Federal and state statutes and regulations recognize the Constitutional rights of residents of state facilities. For example, 42 CFR § 420(a), imposing a duty on DSHS to protect client rights to:

(a) allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process, 42 CFR 420(a)(3);

(b) ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail, 42 CFR 420(a)(9);

(c) ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans, 42 CFR 420(a)(10); and,

(d) ensure clients the opportunity to participate in social, religious, and community group activities, 42 CFR 420(a)(11).

These standards are a condition of continued federal financial participation. DSHS has taken direct action in this court to undercut these rights exercised by the Guardians.

3. Limitations of the Right.

One limitation to the exercise of the right to petition is when such a limitation is justified by an individual's treatment plan. There is no such limitation in this case.

There is no other known federal or state case precedent, or federal or state statute or regulation, which limits the exercise of the right to petition as set forth herein. Such limitations, should they exist, are not narrowly drawn to protect a compelling state interest.

The only other known limitation on the right to petition in this case is that of the court exercising its supervisory authority over the Guardians. The Court has the power to limit advocacy activities in order to protect the best interests of Sandy and Rebecca.

However, in this case the Court completely curtailed the Guardians' advocacy activities based on the content of the activity (contacting all government agencies concerning the residence, care, treatment and services provided to them). There is also no finding that the curtailment and prior restraint on the right to petition is in their best interests.

Because there is no justification for limiting the right on the basis that the limitation is in the best interests of Sandra Lamb and Rebecca Robins, the right to petition must prevail and the Guardians must be permitted to fulfill their duties as set forth by the CPG Standards of Practice.

ISSUE 4: The Guardians are Entitled to Attorney Fees on Appeal and Attorney Fees Issues Reserved Before the Trial Court Should Be Remanded

The Guardians reserved the issue of attorney fees before the trial court. The Guardians request that fees for proceedings for the trial court be awarded with the benefit of knowing the disposition of all the issues on appeal in this Court, and ask that the issue of attorney fees be remanded or decided by the trial court below.

Under RCW 11.96A.150 (App), the trial court, and this Court on appeal, may order reasonable attorneys fees for attorney fees and costs incurred on appeal from, inter alia, any party to the proceedings. The Court here has broad discretion to decide the

issue of attorney fees and costs.[23]

The Guardians request that the attorneys fees incurred on appeal be awarded to the Guardians from the State pursuant to RCW 11.96A.150(1) and RAP 18.1. One factor for consideration is the unfairness associated with requiring Sandra Lamb to pay to vindicate her Constitutional rights and her best interests against the more resourceful State. Another factor the Court should consider is the obligation imposed on the State under federal regulation to protect Sandy's and Rebecca's Constitutional rights and the conflict of interest which exists because the State appears in the guardianship court and on appeal to oppose the exercise of Constitutional rights. Finally, the Court may wish to examine some of the outrageous statements of fact alleged in the trial court below asserting that guardian fees are paid from federal funds or deprive the State from earning interest on State funds. None of those statements are true and have never been corrected. The Guardians reserve the right to file supportive documentation for their request for attorney fees and costs.

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[23] The trial court below has authorized the Trustees of the Sandra Lamb Special Needs Trust to incur attorney fees and costs and has approved the payment of attorney fees and costs from the Trust without prejudice to the issue of attorney fees requested on appeal or as between other parties.

V. RELIEF SOUGHT.

The Guardians respectfully request that this honorable Court:

A. Reverse the superior court's order on the motion to revise and reinstate the Commissioner's Orders of June 6, 2008;

B. Determine Sandy's and Rebecca's income eligibility under federal law;

C. Dismiss or deny the Cross-Appeal;

D. Award attorney fees, costs, and expenses pursuant to RCW 11.96A.150, RAP 18.1, other applicable statute, or other applicable rule in equity or law;

E. For such other relief as the Court finds suitable, just, and equitable.

February 23, 2009

Respectfully submitted,

Michael L. Johnson, WSBA #28172
Counsel for the Appellants

CERTIFICATE OF SERVICE

I hereby certify that on February 23, 2009 I caused a copy of the Opening Brief and Appendix to be served on Jonathon Bashford, counsel for the State of Washington, by delivering the same by PDF attachment to e-mail.

February 23, 2009

Michael L. Johnson, WSBA #28172

IN THE COURT OF APPEALS, DIVISION I,
OF THE STATE OF WASHINGTON

No. 62711-2-I

In the Matter of the
GUARDIANSHIP OF SANDRA LAMB

APPENDIX OF AUTHORITIES

Michael L. Johnson, Counsel for the Guardians
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WSBA #28172
February 23, 2009

RCW 11.88.005
Legislative intent.

It is the intent of the legislature to protect the liberty and autonomy of all people of this state, and to enable them to exercise their rights under the law to the maximum extent, consistent with the capacity of each person. The legislature recognizes that people with incapacities have unique abilities and needs, and that some people with incapacities cannot exercise their rights or provide for their basic needs without the help of a guardian. However, their liberty and autonomy should be restricted through the guardianship process only to the minimum extent necessary to adequately provide for their own health or safety, or to adequately manage their financial affairs.

[1990 c 122 § 1; 1977 ex.s. c 309 § 1; 1975 1st ex.s. c 95 § 1.]

Notes:

Effective date -- 1990 c 122: "This act shall take effect on July 1, 1991." [1990 c 122 § 38.]

Severability -- 1977 ex.s. c 309: "If any provision of this 1977 amendatory act, or its application to any person or circumstance is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances is not affected." [1977 ex.s. c 309 § 18.]

RCW 11.92.043
Additional duties.

It shall be the duty of the guardian or limited guardian of the person:

(1) To file within three months after appointment a personal care plan for the incapacitated person which shall include (a) an assessment of the incapacitated person's physical, mental, and emotional needs and of such person's ability to perform or assist in activities of daily living, and (b) the guardian's specific plan for meeting the identified and emerging personal care needs of the incapacitated person.

(2) To file annually or, where a guardian of the estate has been appointed, at the time an account is required to be filed under RCW 11.92.040, a report on the status of the incapacitated person, which shall include:

(a) The address and name of the incapacitated person and all residential changes during the period;

(b) The services or programs which the incapacitated person receives;

(c) The medical status of the incapacitated person;

(d) The mental status of the incapacitated person;

(e) Changes in the functional abilities of the incapacitated person;

(f) Activities of the guardian for the period;

(g) Any recommended changes in the scope of the authority of the guardian;

(h) The identity of any professionals who have assisted the incapacitated person during the period.

(3) To report to the court within thirty days any substantial change in the incapacitated person's condition, or any changes in residence of the incapacitated person.

(4) Consistent with the powers granted by the court, to care for and maintain the incapacitated person in the setting least restrictive to the incapacitated person's freedom and appropriate to the incapacitated person's personal care needs, assert the incapacitated person's rights and best interests, and if the incapacitated person is a minor or where otherwise appropriate, to see that the incapacitated person receives appropriate training and education and that the incapacitated person has the opportunity to learn a trade, occupation, or profession.

(5) Consistent with RCW 7.70.065, to provide timely, informed consent for health care of the incapacitated person, except in the case of a limited guardian where such power is not expressly provided for in the order of appointment or subsequent modifying order as provided in RCW 11.88.125 as now or hereafter amended, the standby guardian or standby limited guardian may provide timely, informed consent to necessary medical procedures if the guardian or limited guardian cannot be located within four hours after the need for such consent arises. No guardian, limited guardian, or standby guardian may involuntarily commit for mental health treatment, observation, or evaluation an alleged incapacitated person who is unable or unwilling to give informed consent to such commitment unless the procedures for involuntary commitment set forth in chapter 71.05 or 72.23 RCW are followed. Nothing in this section shall be construed to allow a guardian, limited guardian, or standby guardian to consent to:

(a) Therapy or other procedure which induces convulsion;

(b) Surgery solely for the purpose of psychosurgery;

(c) Other psychiatric or mental health procedures that restrict physical freedom of movement, or the rights set forth in *RCW 71.05.370.

A guardian, limited guardian, or standby guardian who believes these procedures are necessary for the proper care and maintenance of the incapacitated person shall petition the court for an order unless the court has previously approved the procedure within the past thirty days. The court may order the procedure only after an attorney is appointed in accordance with RCW 11.88.045 if no attorney has previously appeared, notice is given, and a hearing is held in accordance with RCW 11.88.040.

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[1991 c 289 § 11; 1990 c 122 § 21.]

Notes:

***Reviser's note:** RCW 71.05.370 was recodified as RCW 71.05.217 pursuant to 2005 c 504 § 108, effective July 1, 2005.

Effective date -- 1990 c 122: See note following RCW 11.88.005.

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Standards of Practice Regulation (400)

400 Standards of Practice

The following standards apply to all Certified Professional Guardians (Guardian). Standards apply only to the degree that the court has granted the authority contemplated in a given standard.

401 General

A guardian shall exercise care and diligence when making decisions on behalf of an incapacitated person. The civil rights and liberties of the incapacitated person shall be protected. The independence and self-reliance of the incapacitated person shall be maximized to the greatest extent consistent with their protection and safety.

401.1 The guardian shall at all times be thoroughly familiar with RCW 11.88, RCW 11.92, GR 23, these standards, and any other regulations or statutes which govern the conduct of the guardian in the management of affairs of an incapacitated person. When a question exists between the standards and a statute, timely direction shall be sought from the court. If a guardian is aware of a court order of the court in a specific case which may lead to a conflict with these regulations, the guardian shall disclose this to the court.

401.2 The guardian shall seek legal advice as necessary to know how the law applies to specific decisions.

401.3 The guardian shall provide reports and accountings that are timely, complete, accurate, understandable, and in a form acceptable to the court.

401.4 The guardian shall not act outside of the authority granted by the court.

401.5 The guardian shall protect the personal and economic interests of the incapacitated person and foster growth, independence, and self-reliance.

401.6 The guardian must know and acknowledge personal limits of knowledge and expertise and shall assure that qualified persons provide services to the incapacitated person.

401.7 Whenever feasible a guardian shall consult with the incapacitated person, and shall treat with respect, the feelings, values, and opinions of the incapacitated person. Wherever possible, the guardian shall acknowledge the residual capacity of the incapacitated person to participate in or make some decisions.

401.8 When the guardian has limited authority the guardian shall work cooperatively with the incapacitated person or with others who have authority in other areas for the benefit of the incapacitated person.

401.9 The guardian shall cooperate with and carefully consider the views and opinions of professionals, relatives, and friends who are knowledgeable about the incapacitated person.

401.10 The guardian shall seek independent professional evaluations, assessments, and opinions when necessary to identify the incapacitated person's needs and best interests.

401.11 The guardian shall recognize that his or her decisions are open to the scrutiny of other interested parties and, consequently, to criticism and challenge. Nonetheless, subject to orders of the court, the guardian alone is ultimately responsible for decisions made on behalf of the incapacitated person.

401.12 When possible, the guardian will defer to an incapacitated person's autonomous capacity to make decisions.

401.13 A guardian shall not disclose personal or other sensitive information about the incapacitated person to third parties except when necessary and appropriate to the needs of the incapacitated person.

401.14 The duties of a guardian to an incapacitated person are not conditioned upon the person's ability to compensate the guardian.

401.15 Guardians of the Person shall have meaningful in-person contact with their clients as needed and shall maintain telephone contact with care providers, medical staff, and others who manage aspects of care as needed and appropriate. Meaningful in-person contact shall provide the opportunity to observe the incapacitated person's circumstances and interactions with care givers.

401.16 Guardians of the Estate only shall maintain meaningful in-person contact with their clients as necessary to verify the individual's condition and status and that financial arrangements are appropriate.

401.17 All certified professional guardians and guardian agencies have a duty by statute to appoint a standby guardian. In appointing a standby guardian it is the best practice to appoint a certified professional guardian unless otherwise authorized by the local court with jurisdiction. (Amended January 9, 2006).

402 Decision Standards

All decisions and activities of the guardian shall be made according to the applicable decision standard.

402.1 The primary standard is the Substituted Judgment Standard. This means that the guardian shall make reasonable efforts to ascertain the incapacitated person's historic preferences and shall give significant weight to such preferences. Competent preferences may be inferred from past statements or actions of the incapacitated person.

402.2 When the competent preferences of an incapacitated person cannot be ascertained, the guardian is responsible for making decisions which are in the best interests of the incapacitated person. A determination of the best interests of the incapacitated person shall include consideration of the stated preferences of the incapacitated person.

403 Ethics

403 Ethics

The guardian shall exhibit the highest degree of trust, loyalty, attentiveness, and fidelity in relation to the incapacitated person.

403.1 The guardian shall avoid self-dealing, conflict of interest, and the appearance of a conflict of interest. Self-dealing or conflict of interest arise when the guardian has some personal, family, or agency interest from which a personal benefit would be derived. Any potential conflict shall be disclosed to the court immediately.

403.2 All expenses paid or incurred on behalf of the incapacitated person by the guardian shall be documented, reasonable in amount, and incurred for the incapacitated person's welfare.

403.3 All compensation for the services of the guardian shall be documented, reasonable in amount, and incurred for the incapacitated person's welfare. The guardian shall not pay or advance himself/herself fees or expenses except as approved by the court.

403.4 Provision of compensated services other than guardianship services to an incapacitated person by the guardian shall be considered a potential conflict of interest, which must be fully disclosed.

403.5 An organization whose primary activities are provision of therapeutic, clinical, residential, or medical services shall not act as guardian for one of its patients or clients. Employees, agents, or components of such an organization shall not act as guardian for one of its patients or clients.

403.6 The guardian shall disclose to the court and interested parties all compensation, fees and expenses requested, charged, or received in a guardianship case.

403.7 Payment of fees or other compensation for guardianship services by a party other than the incapacitated person is a potential conflict of interest which shall be fully disclosed.

403.8 The guardian shall protect the incapacitated person's rights and best interests against infringement by third parties.

403.9 The guardian shall, whenever possible, provide requested information to the incapacitated person unless the guardian is reasonably certain that substantial harm will result from providing such information. This information shall include, but not be limited to, regular reports on the status of investments and operating accounts, and on the costs and disbursements necessary to manage the incapacitated person's estate, medical and other personal information related to the care of the incapacitated person.

403.10 Unless otherwise directed by the court, the guardian shall provide copies of all material filed with the court and notice of all hearings in the guardianship to the incapacitated person.

404 Residential Decisions

The guardian shall ensure that the incapacitated person resides in the least restrictive environment that is appropriate and available.

404.1 The guardian shall acknowledge the need to allow all persons the opportunity to engage in activities and live in conditions which are culturally and socially acceptable within the context of the incapacitated person's cultural and life values; or, when cultural and life values cannot be determined, conditions which are culturally and socially acceptable.

404.2 The guardian shall take reasonable measures to effectuate the incapacitated person's residential preferences.

404.3 The guardian shall know the current state of the law regarding limits on the guardian's authority as to residential decisions.

404.4 The guardian shall not remove the incapacitated person from his or her home or separate the incapacitated person from family and friends unless such removal is necessary to prevent significant harm or because of financial constraints. The guardian shall make reasonable efforts to ensure the incapacitated person resides at the incapacitated person's home or in a community setting.

404.5 The guardian shall, to the extent possible, select residential placements which enhance the quality of life of the incapacitated person, provide the opportunity to maximize the independence of the incapacitated person, and provide for physical comfort and safety.

404.6 A relocation should include consultation with professionals actively involved in the care of the incapacitated person, the incapacitated person, objective third parties and, whenever possible, appropriately involved family and friends of the incapacitated person.

404.7 The guardian shall, as necessary, thoroughly research and evaluate the incapacitated person's residential alternatives.

404.8 The guardian shall regularly monitor the incapacitated person's residential placement to ensure appropriateness and that such placement is the least restrictive alternative. The guardian shall consent to changes, as they become necessary, advantageous, or otherwise in the incapacitated person's best interests. The guardian shall consider that even changes within an existing residential facility have an impact on the quality of life of the incapacitated person.

404.9 Should the only available placement not be the most appropriate or least restrictive, the guardian shall regularly review alternatives to the placement and shall make reasonable efforts to arrange an appropriate and least restrictive residence.

405 Medical Decisions

The guardian shall provide informed consent on behalf of the incapacitated person for the provision of care, treatment and services and shall ensure that such care, treatment and services represents the least restrictive form of intervention that is appropriate and available.

405.1 The guardian shall monitor the care, treatment, and services the incapacitated person is receiving to ensure that it is appropriate. The guardian shall consent to changes in service as necessary, advantageous, or in the best interests of the incapacitated person.

405.2 The guardian shall actively promote the health of the incapacitated person by arranging for regular preventive care including but not limited to dental care, diagnostic testing, and routine medical examinations.

405.3 The guardian shall be available at all times to respond to urgent need for medical decisions. The guardian shall provide directives regarding treatment or non-treatment to be followed by medical staff in emergencies.

405.4 In the event the only available treatment, care or services are not the most appropriate and least restrictive, the guardian shall advocate for the incapacitated person's right to appropriate and least restrictive treatment, care or services.

405.5 The guardian shall be fully informed as to risks and benefits to the incapacitated person prior to seeking advance court authorization for medical treatment when law requires such authorization.

405.6 The guardian shall be familiar with the law regarding the withholding or withdrawal of life-sustaining treatment.

406 Financial Management

The guardian shall assure competent management of the property and income of the estate. In the discharge of this duty, the guardian shall exercise the highest level of fiduciary responsibility, intelligence, prudence, and diligence and avoid any self-interest.

406.1 The guardian shall know and obey the law related to managing an incapacitated person's estate. Such knowledge shall include statues relating to the investment of assets, restrictions imposed on investing and expenditures by RCW 11.88 and 11.92, and laws relating to employment, income, and taxes. The guardian shall hire competent professionals as appropriate to assure compliance with all statues and regulations relating to the management of funds.

406.2 The guardian shall maintain all bonding, blocking, and insurance requirements as may be required by the court.

406.3 The guardian shall manage the estate with the primary goal of providing for the needs of the incapacitated person.

406.4 In certain cases, guardian shall consider the needs of the incapacitated person's Dependents for support or maintenance, provided appropriate authority for such support is obtained in advance. The wishes of the incapacitated person as well as past behavior can be considered, bearing in mind both foreseeable financial requirements of the incapacitated person and the advantages and disadvantages to the incapacitated person of such support or maintenance.

406.5 The guardian shall exercise prudence in investment, shall periodically review the incapacitated person's situation and assets, and make recommendations regarding appropriate investments. In the exercise of prudence the guardian shall:

406.5.1 Not allow assets to sit idle except for good reasons.

406.5.2 Consider the tax consequences of decisions.

406.5.3 Consider the incapacitated person's long term ability to sustain costs of arrangements made by the guardian.

406.5.4 Consider the incapacitated person's ability to gain the benefits of specific decisions.

406.5.5 Consider the costs incurred in managing investments, including the costs of the guardian, those specialists hired by the guardian, and the costs of the investment vehicles.

406.5.6 Consider the incapacitated person's historical investment pattern and tolerance for risk, lifestyle needs, care and medical needs, estate considerations, tax consequences, and life expectancy.

406.6 When the available estate of the incapacitated person is sufficient, the guardian may petition the court for authority to make such gifts as are consistent with the wishes or past behavior of the incapacitated person, bearing in mind both foreseeable requirements of the incapacitated person and the advantages and disadvantages to the incapacitated person of such gifts, including tax consequences.

406.7 A guardian shall not accept a gift from an incapacitated person or their estate other than ordinary social hospitality.

406.8 When it is likely that the incapacitated person's estate will be exhausted, the guardian shall, as appropriate, make plans and take necessary steps to acquire public benefits on behalf of the incapacitated person. When implementing necessary changes in the incapacitated person's lifestyle, the guardian shall seek to minimize the stress of any transition.

406.9 There shall be no self-interest in the management of the estate by the guardian; the guardian shall exercise caution to avoid even the appearance of self-interest.

406.10 A guardian shall not commingle the funds of an incapacitated person with funds of the guardian or the funds of staff. A guardian may consolidate client accounts, using appropriate accounting software and procedures, including pro-rata assignment of interest earned and fees paid and accurate individual accounting for each client's funds, provided the guardian has received specific authority from the court to do so. Each payment from a consolidated account shall be from funds held in the account on behalf of the individual for whom the payment is made.

406.11 The guardian shall not borrow from an incapacitated person. A guardian shall not lend funds at interest to an incapacitated person.

406.12 The responsibility to protect and preserve the guardianship estate rests with the certified guardian appointed by the court. When the guardian is an agency, this responsibility is that of the agency and the certified guardians identified with the Certified Professional Guardian Board as the responsible guardians for the agency. While it may be appropriate and necessary to retain and reasonably rely upon the services of knowledgeable individuals or entities to assist in the performance of duties, it is the responsibility of the guardian to provide appropriate oversight and review, in order to preserve the guardianship estate. (Amended September 11, 2006).

407 Changes of Circumstances

The guardian has an affirmative obligation to be alert to changes in the incapacitated person's condition or circumstances and report to the court when an increase or reduction in the authority of the guardian should be considered.

407.1 The guardian shall seek out information that will provide a basis for termination or limitation of the guardianship.

407.2 Upon indication that termination or limitation of the guardianship order is warranted, the guardian shall request court action.

407.3 The guardian shall assist the incapacitated person to terminate or limit the guardianship and arrange for independent representation for the incapacitated person when necessary.

407.4 If the guardianship is a limited guardianship, the guardian shall report to the court when there are circumstances in which the incapacitated person appears to require assistance which exceeds the authority of the guardian.

407.5 If the guardianship is of the person only, the guardian shall report to the court when protection of the incapacitated person's estate may be necessary.

407.6 If the guardianship is of the estate only, the guardian shall report to the court when protection of the person may be necessary.

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408 Applicable Law

The guardian shall perform duties and discharge obligations in accordance with current Washington law governing the certification of guardian. In each guardianship, the guardian shall comply with the requirements of the court that made the appointment.

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[Code of Federal Regulations]
[Title 42, Volume 4]
[Revised as of October 1, 2008]
From the U.S. Government Printing Office via GPO Access
[CITE: 42CFR483.420]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 483_REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES--
Table of Contents

Subpart I_Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

Sec. 483.420 Condition of participation: Client protections.

(a) Standard: Protection of clients' rights. The facility must ensure the rights of all clients. Therefore, the facility must--

(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility;

(2) Inform each client, parent (if the client is a minor), or legal guardian, of

the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;

(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs;

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail;

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;

(11) Ensure clients the opportunity to participate in social, religious, and community group activities;

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in his or her own clothing each day; and

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(13) Permit a husband and wife who both reside in the facility to share a room.

(b) Standard: Client finances. (1) The facility must establish and maintain a system that--

(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and

(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

(c) Standard: Communication with clients, parents, and guardians. The facility must--

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

(2) Answer communications from clients' families and friends promptly and appropriately;

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

(d) Standard: Staff treatment of clients. (1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

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(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

(3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

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RCW 11.88.120
Modification or termination of guardianship — Procedure.

(1) At any time after establishment of a guardianship or appointment of a guardian, the court may, upon the death of the guardian or limited guardian, or, for other good reason, modify or terminate the guardianship or replace the guardian or limited guardian.

(2) Any person, including an incapacitated person, may apply to the court for an order to modify or terminate a guardianship or to replace a guardian or limited guardian. If applicants are represented by counsel, counsel shall move for an order to show cause why the relief requested should not be granted. If applicants are not represented by counsel, they may move for an order to show cause, or they may deliver a written request to the clerk of the court.

(3) By the next judicial day after receipt of an unrepresented person's request to modify or terminate a guardianship order, or to replace a guardian or limited guardian, the clerk shall deliver the request to the court. The court may (a) direct the clerk to schedule a hearing, (b) appoint a guardian ad litem to investigate the issues raised by the application or to take any emergency action the court deems necessary to protect the incapacitated person until a hearing can be held, or (c) deny the application without scheduling a hearing, if it appears based on documents in the court file that the application is frivolous. Any denial of an application without a hearing shall be in writing with the reasons for the denial explained. A copy of the order shall be mailed by the clerk to the applicant, to the guardian, and to any other person entitled to receive notice of proceedings in the matter. Unless within thirty days after receiving the request from the clerk the court directs otherwise, the clerk shall schedule a hearing on the request and mail notice to the guardian, the incapacitated person, the applicant, all counsel of record, and any other person entitled to receive notice of proceedings in the matter.

(4) In a hearing on an application to modify or terminate a guardianship, or to replace a guardian or limited guardian, the court may grant such relief as it deems just and in the best interest of the incapacitated person.

(5) The court may order persons who have been removed as guardians to deliver any property or records belonging to the incapacitated person in accordance with the court's order. Similarly, when guardians have died or been removed and property or records of an incapacitated person are being held by any other person, the court may order that person to deliver it in accordance with the court's order. Disobedience of an order to deliver shall be punishable as contempt of court.

[1991 c 289 § 7; 1990 c 122 § 14; 1977 ex.s. c 309 § 9; 1975 1st ex.s. c 95 § 14; 1965 c 145 § 11.88.120. Prior: 1917 c 156 § 209; RRS § 1579; prior: Code 1881 § 1616; 1860 p 227 § 333; 1855 p 17 § 11.]

Notes:

Effective date -- 1990 c 122: See note following RCW 11.88.005.

Severability -- 1977 ex.s. c 309: See note following RCW 11.88.005.

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§ 1396a. State plans for medical assistance

(a) **Contents.** A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 [42 USCS § 1396b] are authorized by this title [42 USCS §§ 1396 et seq.]; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor, and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;

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(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI [42 USCS §§ 301 et seq. or 1381 et seq.] (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.], or by the agency or agencies administering the supplemental security income program established under title XVI [42 USCS §§ 1381 et seq.] or the State Plan approved under part A of title IV [42 USCS §§ 601 et seq.] if the State is not eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.];

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864(a) [42 USCS § 1395aa(a)]), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) [42 USCS § 1395x(e)(9)] or paragraphs (16) and (17) of section 1861(s) [42 USCS § 1395x(s)(16) and (17)], or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G) [42 USCS § 1395x(aa)(2)(G)];

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a) [42 USCS § 1396d(a)(1)–(5), (17) and (21)], to—

(i) all individuals—

(9) (10) (A)

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(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI , or part A or part E of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq. or 670 et seq.] (including individuals eligible under this title [42 USCS §§ 1396 et seq.] by reason of section 402(a)(37), 406(h), or 473(b) [42 USCS § 673(b)], or considered by the State to be receiving such aid as authorized under section 482(e)(6)),

(II) with respect to whom supplemental security income benefits are being paid under title XVI [42 USCS § 1381 et seq.] (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P. L. 104-193) [enacted Aug. 22, 1996]) and would continue to be paid but for the enactment of that section or who are qualified severely impaired individuals (as defined in section 1905(q) [42 USCS § 1396d(q)]),

(III) who are qualified pregnant women or children as defined in section 1905(n) [42 USCS § 1396d(n)],

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family; [,] or

(V) who are qualified family members as defined in section 1905(m)(1) [42 USCS § 1396d(m)(1)],

(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family, or

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family; [and]

(a)(10)(A) (ii) at the option of the State, to any group or groups of individuals described in section 1905(a) [42 USCS § 1396d(a)] (or, in the case of individuals described in section 1905(a)(i) [42 USCS § 1396d(a)(i)], to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

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(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI [42 USCS §§ 1381 et seq.], or a State supplementary payment; [,]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C) [42 USCS § 1396b(f)(4)(C)],

(VI) who would be eligible under the State plan under this title [42 USCS §§ 1396 et seq.] if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1915 [42 USCS § 1396n(c), (d), or (e)] they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1915 [42 USCS § 1396n(c), (d), or (e)],

(VII) who would be eligible under the State plan under this title [42 USCS §§ 1396 et seq.] if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o) [42 USCS § 1396d(o)]; [,]

(VIII) who is a child described in section 1905(a)(i) [42 USCS § 1396d(a)(i)]—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV [42 USCS §§ 671 et seq.]) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of title IV [42 USCS §§ 670 et seq.] were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of title IV [42 USCS §§ 601 et seq.]; [,]

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(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII); [,]

(X) who are described in subsection (m)(1); [,]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under title XVI [42 USCS §§ 1381 et seq.]), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1616 or 1634 [42 USCS § 1382e or 1383c];

(XII) who are described in subsection (z)(1) (relating to certain TB infected individuals);

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 USCS § 9902(2)]) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B) [42 USCS § 1396d(q)(2)(B)], would be considered to be receiving supplemental security income (subject, notwithstanding section 1916 [42 USCS § 1396o], to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

(XIV) who are optional targeted low-income children described in section 1905(u)(2)(B) [42 USCS § 1396d(u)(2)(B)];

(XV) who, but for earnings in excess of the limit established under section 1905(q)(2)(B) [42 USCS § 1396d(q)(2)(B)], would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;

(XVI) who are employed individuals with a medically improved disability described in section 1905(v)(1) [42 USCS § 1396d(v)(1)] and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);

(XVII) who are independent foster care adolescents (as defined in section 1905(w)(1) [42 USCS § 1396d(w)(1)]), or who are within any reasonable categories of such adolescents specified by the State; or

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(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) [42 USCS § 1396d(a)] who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) [42 USCS § 1396d(a)(1)–(5) and (17)] or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services; and

(E)(i) but, for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3) [42 USCS § 1396d(p)(3)]) for qualified medicare beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)];

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) [42 USCS § 1396d(p)(3)(A)(i)] for qualified disabled and working individuals described in section 1905(s) [42 USCS § 1396d(s)];

(iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) [42 USCS § 1396d(p)(3)(A)(ii)] subject to section 1905(p)(4) [42 USCS § 1396d(p)(4)], for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) [42 USCS § 1396d(p)(2)] but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1933 and 1905(p)(4) [42 USCS §§ 1396u-3, 1396d(p)(4)], for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2002)—

(I) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) [42 USCS § 1396d(p)(3)(A)(ii)] for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) [42 USCS § 1396d(p)(2)] and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan, and

(II) for the portion of medicare cost-sharing described in section 1905(p)(3)(A)(ii) [42 USCS § 1396d(p)(3)(A)(ii)] that is attributable to the operation of the amendments made by (and subsection (e)(3) of) section 4611 of the Balanced Budget Act of 1997 for individuals who would be described in subclause (I) if "135 percent" and "175 percent" were substituted for "120 percent" and "135 percent" respectively;

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in section 1902(u)(1) [subsec. (u)(1) of this section]; and

(G) that, in applying eligibility criteria of the supplemental security income program under title XVI [42 USCS §§ 1381 et seq.] for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1613 [42 USCS § 1382b];

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except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) [42 USCS § 1396d(a)(4), (14) or (16)] to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII [42 USCS §§ 1395j et seq.] to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 [42 USCS § 1395v] or by reason of the payment of premiums under such title [42 USCS §§ 1395 et seq.] by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII [42 USCS §§ 1395j et seq.] for individuals eligible for benefits under such part [42 USCS §§ 1395j et seq.], shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) [42 USCS § 1396o(a)(2) or (b)(2)] shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) [42 USCS § 1396d(o)] to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII [42 USCS §§ 1395 et seq.], and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in

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subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3) [42 USCS § 1396d(p)(3)]), subject to the provisions of subsection (n) and section 1916(b) [42 USCS § 1396o(b)], (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A) [42 USCS § 1396r-4], as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 [42 USCS § 1396e] shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)), and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer;

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical as-

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sistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) title V [42 USCS §§ 701 et seq.], (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such title [42 USCS §§ 701 et seq.] or allotment and which are included in the State plan approved under this section[,](ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1903 [42 USCS § 1396b], and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this title [42 USCS §§ 1396 et seq.], including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966 [42 USCS § 1786];

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923 [42 USCS § 1396r-4]) the situation of hospitals which serve a disproportionate number of low-income patients with special needs; and

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII [42 USCS §§ 1395c et seq.] and for payment of amounts under section 1905(o)(3) [42 USCS § 1396d(o)(3)]; except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95

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percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916 [42 USCS § 1396o];

(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) [42 USCS § 1396d(a)(2)] under the plan in accordance with subsection [(bb)](aa);

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (l)(3), (m)(3), and (m)(4), include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq.], and with respect to whom supplemental security income benefits are not being paid under title XVI [42 USCS §§ 1381 et seq.], based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title [42 USCS §§ 1396 et seq.], (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq.], or to have paid with respect to him supplemental security income benefits under title XVI [42 USCS §§ 1381 et seq.]) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under 21 or (with respect to States eligible to participate in the State program established under title XVI [42 USCS §§ 1381 et seq.]), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 [42 USCS § 1382c] (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1903(f)(2)(B) [42 USCS § 1396b(f)(2)(B)], or otherwise and regardless of

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whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1917 [42 USCS § 1396p] with respect to liens, adjustments and recoveries of medical assistance correctly paid, [,] transfers of assets, and treatment of certain trusts;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A)(i) and (ii) [42 USCS § 303(a)(4)(A)(i) and (ii)] or section 1603(a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under

vices provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of title IV [42 USCS §§ 601 et seq.] pursuant to section 402(a)(43) [42 USCS § 602(a)(43)] shall not be construed as denying (or permitting a State to deny) medical assistance under this title [42 USCS §§ 1396 et seq.] to such individual, child, or woman who is eligible for assistance under this title [42 USCS §§ 1396 et seq.] on a basis other than the receipt of aid under such part [42 USCS §§ 601 et seq.].

(B) If an individual, child, or pregnant woman is receiving aid under part A of title IV [42 USCS §§ 601 et seq.] and such aid is terminated pursuant to section 402(a)(43) [42 USCS § 602(a)(43)], the State may not discontinue medical assistance under this title [42 USCS §§ 1396 et seq.] for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this title [42 USCS §§ 1396 et seq.] on a basis other than the receipt of aid under such part [42 USCS §§ 601 et seq.].

(11)(A) In the case of an individual who is enrolled with a group health plan under section 1906 [42 USCS § 1396e] and who would (but for this paragraph) lose eligibility for benefits under this title [42 USCS §§ 1396 et seq.] before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title [42 USCS §§ 1396 et seq.], that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective.

(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

(A) the end of a period (not to exceed 12 months) following the determination; or

(B) the time that the individual exceeds that age.

(f) Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals. Notwithstanding any other provision of this title [42 USCS §§ 1396 et seq.], except as provided in subsection (e) and section 1619(b)(3) and section 1924 [42 USCS

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§ 1382h(b)(3) and § 1396r-5], except with respect to qualified disabled and working individuals (described in section 1905(s) [42 USCS § 1396d(s)]), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1), no State not eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.] shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI [42 USCS §§ 1381 et seq.]) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title [42 USCS §§ 1396 et seq.] and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) [42 USCS § 1396b(f)] (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof, is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI [42 USCS §§ 1381 et seq.], with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) Reduction of aid or assistance to providers of services attempting to collect from beneficiary in violation of third-party provisions. In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

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tion 1128 or 1128A [42 USCS § 1320a-7 or 1320a-7a] for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term ''exclude'' includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q) Minimum monthly personal needs allowance deduction; ''institutionalized individual or couple'' defined. (1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term ''institutionalized individual or couple'' means an individual or married couple—

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title [42 USCS §§ 1396 et seq.] throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph [subsection] is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r) Disregarding payments for certain medical expenses by institutionalized individuals. (1)(A) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) [42 USCS §§ 1396a(a)(17) and 1396r-5(d)(1)(D)] and for purposes of a waiver under section 1915 [42 USCS § 1396n], with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but

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not covered under the State plan under this title [42 USCS §§ 1396 et seq.], subject to reasonable limits the State may establish on the amount of these expenses.

(B)(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this title [42 USCS §§ 1396 et seq.], a veteran's pension in excess of $90 per month, and

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38, United States Code,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of $90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) [1396d(p)] may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI [42 USCS §§ 1381 et seq.], or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) Adjustment in payment for hospital services furnished to low-income children under the age of 6 years. In order to meet the requirements of subsection (a)[(56)](55), the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1923(b)(1) [42 USCS § 1396r-4(b)(1)], shall—

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

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§ 1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must—

(1)–(6) [Unchanged]

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with—

(A) the administration of the plan; and

(B) at State option, the exchange of information necessary to verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 [42 USCS §§ 1771 et seq.] and free or reduced price lunches under the Richard B. Russell National School Lunch Act [42 USCS §§ 1751 et seq.], in accordance with section 9(b) of that Act [42 USCS § 1758(b)], using data standards and formats established by the State agency;

(8), (9) [Unchanged]

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a) [42 USCS § 1396d(a)(1)–(5), (17) and (21)], to—

(i) all individuals—

(I) [Unchanged]

(II) (aa) with respect to whom supplemental security income benefits are being paid under title XVI [42 USCS § 1381 et seq.] (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) [enacted Aug. 22, 1996] and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1905(q) [42 USCS § 1396d(q)]), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under title XVI [42 USCS §§ 1381 et seq.] if subparagraphs (A) and (B) of section 1611(c)(7) [42 USCS § 1382(c)(7)] were applied without regard to the phrase "the first day of the month following",

(III)–(VII) [Unchanged]

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) [42 USCS § 1396d(a)] (or, in the case of individuals described in section 1905(a)(i) [42 USCS § 1396d(a)(i)], to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I)–(XVI) [Unchanged]

(XVII) who are independent foster care adolescents (as defined in section 1905(w)(1) [42 USCS § 1396d(w)(1)]), or who are within any reasonable categories of such adolescents specified by the State;

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients); or

(XIX) who are disabled children described in subsection (cc)(1);

(B)–(D) [Unchanged]

(E)(i)–(iii) [Unchanged]

(iv) subject to sections 1933 and 1905(p)(4) [42 USCS §§ 1396u-3, 1396d(p)(4)], for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with June 2008) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) [42 USCS § 1396d(p)(3)(A)(ii)] for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) [42 USCS § 1396d(p)(2)] and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

(F), (G) [Unchanged]

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) [42 USCS § 1396d(a)(4), (14) or (16)] to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII [42 USCS §§ 1395j et seq.] to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 [42 USCS § 1395v] or by reason of the payment of premiums under such title [42 USCS §§ 1395 et seq.] by the State agency on behalf of such individuals), or provision for meeting part or all of the

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cost of deductibles, cost sharing, or similar charges under part B of title XVIII [42 USCS §§ 1395j et seq.] for individuals eligible for benefits under such part [42 USCS §§ 1395j et seq.], shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) [42 USCS § 1396o(a)(2) or (b)(2)] shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) [42 USCS § 1396d(o)] to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII [42 USCS §§ 1395 et seq.], and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3) [42 USCS § 1396d(p)(3)]), subject to the provisions of subsection (n) and section 1916(b) [42 USCS § 1396o(b)], (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A) [42 USCS § 1396r-4], as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 [42 USCS § 1396e] shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)), and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer;

(11)–(14) [Unchanged]

(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) [42 USCS § 1396d(a)(2)] under the plan in accordance with subsection (bb);

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(16)–(24) [Unchanged]

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 USCS § 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i), (ii) [Unchanged]

(B)–(F) [Unchanged]

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 USCS § 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title [42 USCS §§ 1396 et seq.] for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 USCS § 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

(26)–(43) [Unchanged]

(44) **[Caution: For application of 1987 amendment of paragraph, see § 4218(b) of Act Dec. 22, 1987, P. L. 100-203, which appears as a note to this section.]** in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan—

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a

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(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title [42 USCS §§ 1396 et seq.], the State agency which administered or supervised the administration of the plan of such State approved under title X [42 USCS §§ 1201 et seq.] (or title XVI [42 USCS §§ 1381 et seq.], insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I [42 USCS §§ 301 et seq.] (or title XVI [42 USCS §§ 1381 et seq.], insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X [42 USCS §§ 1201 et seq.] (or title XVI [42 USCS §§ 1381 et seq.], insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title [42 USCS §§ 1396 et seq.] (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1903(i)(4) [42 USCS § 1396b(i)(4)] shall not apply to a religious nonmedical health care institution (as defined in section 1861(ss)(1) [42 USCS § 1395x(ss)(1)]).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq.] and who for such month was entitled to monthly insurance benefits under title II [42 USCS §§ 401 et seq.] shall for purposes of this title [42 USCS §§ 1396 et seq.] only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II [42 USCS §§ 401 et seq.] resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this title [42 USCS §§ 1396 et seq.], any child who meets the requirements of paragraph (1) or (2) of section 473(b) [42 USCS § 673(b)(1) or (2)] shall be deemed to be a dependent child as defined in section 406 [42 USCS § 606] and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV [42 USCS §§ 601 et seq.] in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v) [42 USCS § 1396b(v)].

(b)–(d) [Unchanged]

(e) Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan; individuals enrolled with health maintenance organizations; persons deemed recipients of supplemental security income or State supplemental payments; entitlement for certain newborns; postpartum eligibility for pregnant women. (1)(A) [Unchanged]

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of title IV [42 USCS §§ 601 et seq.] during the period beginning on April 1, 1990, and ending on September 30, 2003. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV [42 USCS §§ 601 et seq.] and have earned income, see section 1925 [42 USCS § 1396r-6].

(2)–(12) [Unchanged]

(f)–(z) [Unchanged]

(aa) Certain individuals with breast or cervical cancer. Individuals described in this subsection are individuals who—

(1)–(3) [Unchanged]

(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)), but applied without regard to paragraph (1)(F) of such section.

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Health Ass'n v Heckler (1983, CA8 Minn) 720 F2d 965 (criticized in Crayton v Callahan (1997, CA11 Ala) 120 F3d 1217, 53 Soc Sec Rep Serv 914, 23 ADD 595, 11 FLW Fed C 468).

There was question regarding whether claimant was denied due process in her previous application for supplemental security income benefits because it was undetermined whether claimant could act upon notice of denial of disability benefits. Byam v Barnhart (2003, CA2 Vt) 336 F3d 172, 89 Soc Sec Rep Serv 287.

Substantial evidence existed to support denial of disability insurance benefits and supplemental security income benefits when administrative law judge concluded that although claimant's degenerative disc disease, status post right knee injury, and depression combined to more than minimally impact on claimant's ability to perform basic work activity, claimant was able to perform sedentary work based on fact that claimant performed some housework and claimant's depression did not affect his concentration because claimant could drive for short distances, go fishing, and was not taking anti-depressants. Alsip v Barnhart (2002, ND Ill) 84 Soc Sec Rep Serv 686.

PART A. DETERMINATION OF BENEFITS

CROSS REFERENCES

This part is referred to in 42 USCS § 1381a.

§ 1382. Eligibility for benefits

(a) Eligible individual" defined. (1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

(A) whose income, other than income excluded pursuant to section 1612(b) [42 USCS § 1382a(b)], is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1617 [42 USCS § 1382f]) for the calendar year 1974 or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1613(a) [42 USCS § 1382b(a)], are not more than (i) in case such individual has a spouse with whom he is living, the applicable amount determined under paragraph (3)(A), or (ii) in case such individual has no spouse with whom he is living, the applicable amount determined under paragraph (3)(B),

shall be an eligible individual for purposes of this title [42 USCS §§ 1381 et seq.].

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1612(b) [42 USCS § 1382a(b)], is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1617 [42 USCS § 1382f]) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1613(a) [42 USCS § 1382b(a)], are not more than the applicable amount determined under paragraph (3)(A),

shall be an eligible individual for purposes of this title [42 USCS §§ 1381 et seq.].

(3)(A) The dollar amount referred to in clause (i) of paragraph (1)(B), and in paragraph (2)(B), shall be $2,250 prior to January 1, 1985, and shall be increased to $2,400 on January 1, 1985, to $2,550 on January 1, 1986, to $2,700 on January 1, 1987, to $2,850 on January 1, 1988, and to $3,000 on January 1, 1989.

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(B) The dollar amount referred to in clause (ii) of paragraph (1)(B), shall be $1,500 prior to January 1, 1985, and shall be increased to $1,600 on January 1, 1985, to $1,700 on January 1, 1986, to $1,800 on January 1, 1987, to $1,900 on January 1, 1988, and to $2,000 on January 1, 1989.

(b) Amount of benefits. (1) The benefit under this title [42 USCS §§ 1381 et seq.] for an individual who does not have an eligible spouse shall be payable at the rate of $1,752 (or, if greater, the amount determined under section 1617 [42 USCS § 1382f]) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1612(b) [42 USCS § 1382a(b)], of such individual.

(2) The benefit under this title [42 USCS §§ 1381 et seq.] for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1617 [42 USCS § 1382f]) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1612(b) [42 USCS § 1382a(b)], of such individual and spouse.

(c) Period for determination of benefits. (1) An individual's eligibility for a benefit under this title [42 USCS §§ 1381 et seq.] for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraphs (2), (3), (4), (5), and (6) the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Commissioner of Social Security so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Commissioner of Social Security.

(2) The amount of such benefit for the month in which an application for benefits becomes effective (or, if the Commissioner of Social Security so determines, for such month and the following month) and for any month immediately following a month of ineligibility for such benefits (or, if the Commissioner of Social Security so determines, for such month and the following month) shall—

(A) be determined on the basis of the income of the individual and the eligible spouse, if any, of such individual and other relevant circumstances in such month; and

(B) **[Caution: For provisions in effect with respect to benefits payable for months that begin within one year of March 2, 2004, see note below describing amendment made to this subparagraph by Act March 2, 2004.]** in the case of the first month following a period of ineligibility in which eligibility is restored after the first day of such month, bear the same ratio to the amount of the benefit which would have been payable to such individual if eligibility had been restored on the first day of such month as the number of days in such month including and following the date of restoration of eligibility bears to the total number of days in such month.

(3) For purposes of this subsection, an increase in the benefit amount pay-

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able under title II [42 USCS §§ 401 et seq.] (over the amount payable in the preceding month, or, at the election of the Commissioner of Social Security, the second preceding month) to an individual receiving benefits under this title [42 USCS §§ 1381 et seq.] shall be included in the income used to determine the benefit under this title [42 USCS §§ 1381 et seq.] of such individual for any month which is—

(A) the first month in which the benefit amount payable to such individual under this title [42 USCS §§ 1381 et seq.] is increased pursuant to section 1617 [42 USCS § 1382f], or

(B) at the election of the Commissioner of Social Security, the month immediately following such month.

(4)(A) Notwithstanding paragraph (3), if the Commissioner of Social Security determines that reliable information is currently available with respect to the income and other circumstances of an individual for a month (including information with respect to a class of which such individual is a member and information with respect to scheduled cost-of-living adjustments under other benefit programs), the benefit amount of such individual under this title [42 USCS §§ 1381 et seq.] for such month may be determined on the basis of such information.

(B) The Commissioner of Social Security shall prescribe by regulation the circumstances in which information with respect to an event may be taken into account pursuant to subparagraph (A) in determining benefit amounts under this title [42 USCS §§ 1381 et seq.].

(5) Notwithstanding paragraphs (1) and (2), any income which is paid to or on behalf of an individual in any month pursuant to (A) a State program funded under part A of title IV [42 USCS §§ 601 et seq.], (B) section 472 of this Act [42 USCS § 672] (relating to foster care assistance), (C) section 412(e) of the Immigration and Nationality Act [8 USCS § 1522(e)] (relating to assistance for refugees), (D) section 501(a) of Public Law 96-422 [8 USCS § 1522 note] (relating to assistance for Cuban and Haitian entrants), or (E) the Act of November 2, 1921 (42 Stat. 208) [25 USCS § 13], as amended (relating to assistance furnished by the Bureau of Indian Affairs), shall be taken into account in determining the amount of the benefit under this title [42 USCS §§ 1381 et seq.] of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(6) The dollar amount in effect under subsection (b) as a result of any increase in benefits under this title [42 USCS §§ 1381 et seq.] by reason of section 1617 [42 USCS § 1382f] determine the value of any in-kind support and maintenance required to be taken into account in determining the benefit payable under this title [42 USCS §§ 1381 et seq.] to an individual (and the eligible spouse, if any, of the individual) for the 1st 2 months for which the increase in benefits applies.

(7) For purposes of this subsection, an application of an individual for benefits under this title [42 USCS §§ 1381 et seq.] shall be effective on the later of—

(A) the first day of the month following the date such application is filed, or

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(B) the first day of the month following the date such individual becomes eligible for such benefits with respect to such application.

(8) The Commissioner of Social Security may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Commissioner of Social Security shall apply, to the month preceding the month of removal, or, if the Commissioner of Social Security so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.

(9) **[Caution: This paragraph is effective with respect to benefits payable for months that begin on or after one year after March 2, 2004, pursuant to § 433(c) of Act March 2, 2004, P. L. 108-203, which appears as a note to this section.]** (A) Notwithstanding paragraphs (1) and (2), any nonrecurring income which is paid to an individual in the first month of any period of eligibility shall be taken into account in determining the amount of the benefit under this title of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(B) For purposes of subparagraph (A), payments to an individual in varying amounts from the same or similar source for the same or similar purpose shall not be considered to be nonrecurring income.

(10) For purposes of this subsection, remuneration for service performed as a member of a uniformed service may be treated as received in the month in which it was earned, if the Commissioner of Social Security determines that such treatment would promote the economical and efficient administration of the program authorized by this title [42 USCS §§ 1381 et seq.].

(d) Limitation on amount of gross income earned; "gross income" defined. The Commissioner of Social Security may prescribe the circumstances under which, consistently with the purposes of this title [42 USCS §§ 1381 et seq.], the gross income from a trade or business (including farming) will be considered sufficiently large to make an individual ineligible for benefits under this title [42 USCS §§ 1381 et seq.]. For purposes of this subsection, the term "gross income" has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1954 [26 USCS §§ 1 et seq.].

(e) Limitation on eligibility of certain individuals. (1)(A) Except as provided in subparagraphs (B), (C), (D), (E), and (G) no person shall be an eligible individual or eligible spouse for purposes of this title [42 USCS §§ 1381 et seq.] with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is subject to subparagraph (G)), throughout any month subject to subpara-

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graph (G)), in a medical treatment facility receiving payments (with respect to such individual or spouse) under a State plan approved under title XIX [42 USCS §§ 1396 et seq.], or an eligible individual is a child described in section 1614(f)(2)(B) [42 USCS § 1382c(f)(2)(B)], or, in the case of an eligible individual who is a child under the age of 18, receiving payments (with respect to such individual) under any health insurance policy issued by a private provider of such insurance the benefit under this title [42 USCS §§ 1381 et seq.] for such individual for such month shall be payable (subject to subparagraph (E))—

(i) at a rate not in excess of $360 per year (reduced by the amount of any income not excluded pursuant to section 1612(b) [42 USCS § 1382a(b)]) in the case of an individual who does not have an eligible spouse;

(ii) in the case of an individual who has an eligible spouse, if only one of them is in such a facility throughout such month, at a rate not in excess of the sum of—

(I) the rate of $360 per year (reduced by the amount of any income, not excluded pursuant to section 1612(b) [42 USCS § 1382a(b)], of the one who is in such facility), and

(II) the applicable rate specified in subsection (b)(1) (reduced by the amount of any income, not excluded pursuant to section 1612(b) [42 USCS § 1382a(b)], of the other); and

(iii) at a rate not in excess of $720 per year (reduced by the amount of any income not excluded pursuant to section 1612(b) [42 USCS § 1382a(b)]) in the case of an individual who has an eligible spouse, if both of them are in such a facility throughout such month.

For purposes of this subsection, a medical treatment facility that provides services described in section 1917(c)(1)(C) [42 USCS § 1396p(c)(1)(C)] shall be considered to be receiving payments with respect to an individual under a State plan approved under title XIX [42 USCS §§ 1396 et seq.] during any period of ineligibility of such individual provided for under the State plan pursuant to section 1917(c) [42 USCS § 1396p(c)].

(C) As used in subparagraph (A), the term "public institution" does not include a publicly operated community residence which serves no more than 16 residents.

(D) A person may be an eligible individual or eligible spouse for purposes of this title [42 USCS §§ 1381 et seq.] with respect to any month throughout which he is a resident of a public emergency shelter for the homeless (as defined in regulations which shall be prescribed by the Commissioner of Social Security); except that no person shall be an eligible individual or eligible spouse by reason of this subparagraph more than 6 months in any 9-month period.

(E) Notwithstanding subparagraphs (A) and (B), any individual who—

(i)(I) is an inmate of a public institution, the primary purpose of which is the provision of medical or psychiatric care, throughout any month as described in subparagraph (A), or

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security income under Title II and XIV of Social Security Act, 42 USCS §§ 401 et seq., 1381 et seq., Commissioner was granted summary judgment where substantial evidence did not exist showing that claimant met regulatory listing of 20 C.F.R. pt. 404, subpt. P, app. 1, § 1.04B; no evidence of spinal arachnoiditis existed in record Nester v Barnhart (2005, WD Va) 103 Soc Sec Rep Serv 738.

In action in which social security claimant sought judicial review of final decision of Commissioner of Social Security denying claimant's claim for supplemental security income benefits under Social Security Act, 42 USCS § 1381a, claimant's motion for summary judgment was granted and case was remanded to administrative law judge (ALJ) where (1) ALJ failed to consider claimant's alleged obesity; (2) there was nothing in opinion to demonstrate that ALJ considered type, dosage, effectiveness, and/or side effects of medication taken by claimant; and (3) ALJ failed to discuss claimant's daily activities, location, duration, frequency, and intensity of her symptoms or any precipitating and aggravating factors. Jones v Barnhart (2005, ND Ill) 105 Soc Sec Rep Serv 223.

In claimant's 42 USCS § 405(g) action, court reversed and remanded Commissioner of Social Security's denial of disability benefits under Title II of Social Security Act, 42 USCS § 401 et seq., and supplemental security income benefits under Title XVI of Act, 42 USCS § 1381 et seq., action where (1) there was no way to determine what amount of weight ALJ placed on erroneous earning information; and (2) on remand, ALJ should include in hypothetical questions to vocational expert any limitations which he found to exist based upon substantial evidence in record. McKitrick v Barnhart (2005, DC Kan) 364 F Supp 2d 1272.

In action in which social security claimant challenged final decision of Commissioner of Social Security, denying claim for supplemental security income under Social Security Act, 42 USCS § 1381 et seq., decision was vacated and case was remanded to ALJ where (1) although ALJ clearly rejected treating physician's opinions, it was unclear what opinions she accepted and relied upon in concluding that claimant did not suffer from disabling mental impairment; and (2) it was unclear from record before court how ALJ reached such conclusions regarding evidence that was relevant to claimant's mental impairments. Payne v Barnhart (2005, WD Va) 366 F Supp 2d 391.

In action in which claimant appealed from decision of Commissioner of Social Security denying his application for supplemental security income under Title XVI of Social Security Act, 42 USCS § 1381 et seq., Commissioner's decision was affirmed where (1) ALJ considered medical reports and treatment records from claimant's treating physician and examining physicians; (2) although ALJ did not explicitly consider claimant's obesity, it was factored indirectly into ALJ's decision as part of doctors' opinions; (3) ALJ properly applied guiding principles of Medical Vocational Guidelines to conclude that claimant was not disabled; (4) ALJ's hypothetical to vocational expert accurately reflected evidence that was presented by claimant about his physical abilities; and (5) ALJ properly considered all medical evidence. Santiago v Barnhart (2005, ED Pa) 367 F Supp 2d 728, 103 Soc Sec Rep Serv 341.

In action in which social security claimant sought judicial review of final decision of Commissioner of Social Security Administration denying claimant's application for supplemental security income under 42 USCS §§ 1381–1383(f), claimant's motion for summary judgment was granted where: (1) administrative law judge (ALJ) failed to give proper weight to claimant's lengthy and well-documented complaints of subjective pain and fatigue and did not include all of claimant's credibly established nonexertional limitations in her hypothetical question to vocational expert; and (2) vocational expert herself admitted that, if claimant's testimony were deemed credible, he would be unable to work because he indicated he was lying down couple of times day, because of terrible fatigue; and that would preclude appropriate attendance at any competitive employment. Whitmore v Barnhart (2007, DC Del) 469 F Supp 2d 180.

Claimant seeking Supplemental Security Income (SSI) payments under 42 USCS § 1381a was entitled to remand of denial of his request because ALJ improperly made independent medical determination by evaluating claimant's subtest scores from IQ test and concluding that subtest scores would not affect his functional capacity. Corder v Barnhart (2007, ND Ill) 504 F Supp 2d 351.

PART A. DETERMINATION OF BENEFITS

§ 1382. Eligibility for benefits

(a)–(c) [Unchanged]

(d) Limitation on amount of gross income earned; "gross income" defined. The Commissioner of Social Security may prescribe the circumstances under which, consistently with the purposes of this title [42 USCS §§ 1381 et seq.], the gross income from a trade or business (including farming) will be considered sufficiently large to make an individual ineligible for benefits under this title [42 USCS §§ 1381 et seq.]. For purposes of this subsection, the term "gross income" has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1954 [1986] [26 USCS §§ 1 et seq.].

(e)–(i) [Unchanged]

HISTORY; ANCILLARY LAWS AND DIRECTIVES

Explanatory notes:

"1986" has been inserted in brackets in subsec. (d) pursuant to § 2 of Act Oct. 22, 1986, P. L. 99-514, which redesignated the Internal Revenue Code of 1954 (Act Aug. 16, 1954, ch 736) as the Internal Revenue Code of 1986. In redesignating the Internal Revenue Code of 1954 as the Internal Revenue Code of 1986, Congress provided, in Act Oct. 22, 1986, P. L. 99-514, § 2(b), 100 Stat. 2095, for construction of references to the Internal Revenue Code as follows: except when inappropriate, any reference in any law, Executive Order, or other document to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986 and any

Social Security Online
Office of the Chief Actuary

Automatic Increases

SSI Annual Report

SSI payment standards, 1975 & later

Automatic Increases

SSI Federal Payment Amounts

Maximum Federal Supplemental Security Income (SSI) payment amounts increase with the automatic cost-of-living increases that apply to Social Security benefits. The latest such increase, 5.8 percent, becomes effective January 2009.

SSI amounts for 2009

The monthly maximum Federal amounts for 2009 are $674 for an eligible individual, $1,011 for an eligible individual with an eligible spouse, and $338 for an essential person.

In general, monthly amounts for the next year are determined by increasing the *unrounded annual amounts* for the current year by the COLA effective for January of the next year. The new unrounded amounts are then each divided by 12 and the resulting amounts are rounded down to the next lower multiple of $1.

Calculation details

Recipient(s)	Unrounded annual amounts for—		Monthly amounts for 2009
	2008	2009 [a]	
Eligible individual	$7,651.53	$8,095.32	$674
Eligible couple	11,476.00	12,141.61	1,011
Essential person	3,834.53	4,056.93	338

[a] The unrounded amounts for 2009 equal the unrounded amounts for 2008 increased by 5.8 percent.

Payment reduction

The monthly amount is reduced by subtracting monthly countable income. In the case of an eligible individual with an eligible spouse, the amount payable is further divided equally between the two spouses. Some States supplement SSI benefits.

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§ 416.415 Amount of benefits; eligible individual is disabled child under age 18.

(a) If you are a disabled child under age 18 and meet the conditions in § 416.1165(i) for waiver of deeming, your parents' income will not be deemed to you and your benefit rate will be $30 a month.

(b) If you are a disabled child under age 18 and do not meet the conditions in § 416.1165(i) only because your parents' income is not high enough to make you ineligible for SSI but deeming of your parents' income would result in an SSI benefit less than the amount payable if you received benefits as a child under § 416.1165(i), your benefit will be the amount payable if you received benefits as a child under § 416.1165(i).

[60 FR 361, Jan. 4, 1995]

§ 416.420 Determination of benefits; general.

Benefits shall be determined for each month. The amount of the monthly payment will be computed by reducing the benefit rate (see §§ 416.410, 416.412, 416.413, and 416.414) by the amount of countable income as figured under the rules in subpart K of this part. The appropriate month's countable income to be used to determine how much your benefit payment will be for the current month (the month for which a benefit is payable) will be determined as follows:

(a) *General rule.* We generally use the amount of your countable income in the second month prior to the current month to determine how much your benefit amount will be for the current month. We will use the benefit rate (see §§ 416.410 through 416.414), as increased by a cost-of-living adjustment, in determining the value of the one-third reduction or the presumed maximum value, to compute your SSI benefit amount for the first 2 months in which the cost-of-living adjustment is in effect. If you have been receiving an SSI benefit and a Social Security insurance benefit and the latter is increased on the basis of the cost-of-living adjustment or because your benefit is recomputed, we will compute the amount of your SSI benefit for January, the month of an SSI benefit increase, by including in your income the amount by which your Social Security benefit in January exceeds the amount of your Social Security benefit in November. Similarly, we will compute the amount of your SSI benefit for February by including in your income the amount by which your Social Security benefit in February exceeds the amount of your Social Security benefit in December.

Example 1. Mrs. X's benefit amount is being determined for September (the current month). Mrs. X's countable income in July is used to determine the benefit amount for September.

Example 2. Mr. Z's SSI benefit amount is being determined for January (the current month). There has been a cost-of-living increase in SSI benefits effective January. Mr. Z's countable income in November is used to determine the benefit amount for January. In November, Mr. Z had in-kind support and maintenance valued at the presumed maximum value as described in § 416.1140(a). We will use the January benefit rate, as increased by the COLA, to determine the value of the in-kind support and maintenance Mr. Z received in November when we determine Mr. Z's SSI benefit amount for January.

Example 3. Mr. Y's SSI benefit amount is being determined for January (the current month). Mr. Y has Social Security income of $100 in November, $100 in December, and $105 in January. We find the amount by which his Social Security income in January exceeds his Social Security income in November ($5) and add that to his income in November to determine the SSI benefit amount for January.

(b) *Exceptions to the general rule*—(1) *First month of initial eligibility for payment or the first month of eligibility after a month of ineligibility.* We use your countable income in the current month to determine your benefit amount for the first month you are initially eligible for payment of SSI benefits (see § 416.501) or for the first month you again become eligible for SSI benefits after at least a month of ineligibility. Your payment for a first month of reeligibility after at least one-month of ineligibility will be prorated according to the number of days in the month that you are eligible beginning with the date on which you reattain eligibility.

Example: Mrs. Y applies for SSI benefits in September and meets the requirements for eligibility in that month. (We use Mrs. Y's

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countable income in September to determine if she is eligible for SSI in September.) The first month for which she can receive payment is October (see § 416.501). We use Mrs. Y's countable income in October to determine the amount of her benefit for October. If Mrs. Y had been receiving SSI benefits through July, became ineligible for SSI benefits in August, and again became eligible for such benefits in September, we would use Mrs. Y's countable income in September to determine the amount of her benefit for September. In addition, the proration rules discussed above would also apply to determine the amount of benefits in September in this second situation.

(2) *Second month of initial eligibility for payment or second month of eligibility after a month of ineligibility.* We use your countable income in the first month prior to the current month to determine how much your benefit amount will be for the current month when the current month is the second month of initial eligibility for payment or the second month of reeligibility following at least a month of ineligibility. However, if you have been receiving both an SSI benefit and a Social Security insurance benefit and the latter is increased on the basis of the cost-of-living adjustment or because your benefit is recomputed, we will compute the amount of your SSI benefit for January, the month of an SSI benefit increase, by including in your income the amount by which your Social Security benefit in January exceeds the amount of your Social Security benefit in December.

Example: Mrs. Y was initially eligible for payment of SSI benefits in October. Her benefit amount for November will be based on her countable income in October (first prior month).

(3) *Third month of initial eligibility for payment or third month of eligibility after a month of ineligibility.* We use your countable income according to the rule set out in paragraph (a) of this section to determine how much your benefit amount will be for the third month of initial eligibility for payment or the third month of reeligibility after at least a month of ineligibility.

Example: Mrs. Y was initially eligible for payment of SSI benefits in October. Her benefit amount for December will be based on her countable income in October (second prior month).

(4) *Income derived from certain assistance payments.* We use your income in the current month from the programs listed below to determine your benefit amount for that same month. The assistance programs are as follows:

(i) Aid to Families with Dependent Children under title IV-A of the Social Security Act (the Act);

(ii) Foster Care under title IV-E of the Act;

(iii) Refugee Cash Assistance pursuant to section 412(e) of the Immigration and Nationality Act;

(iv) Cuban and Haitian Entrant Assistance pursuant to section 501(a) of Pub. L. 96–422; and

(v) Bureau of Indian Affairs general assistance and child welfare assistance pursuant to 42 Stat. 208 as amended.

(c) *Reliable information which is currently available for determining benefits.* The Commissioner has determined that no reliable information exists which is currently available to use in determining benefit amounts.

(1) *Reliable information.* For purposes of this section *reliable information* means payment information that is maintained on a computer system of records by the government agency determining the payments (e.g., Department of Veterans Affairs, Office of Personnel Management for Federal civil service information and the Railroad Retirement Board).

(2) *Currently available information.* For purposes of this section *currently available information* means information that is available at such time that it permits us to compute and issue a correct benefit for the month the information is pertinent.

(d) *Payment of benefits.* See subpart E of this part for the rules on payments and the minimum monthly benefit (as explained in § 416.503).

[50 FR 48571, Nov. 26, 1985; 50 FR 51514, Dec. 18, 1985, as amended at 54 FR 31657, Aug. 1, 1989; 62 FR 30751, June 5, 1997; 63 FR 33546, June 19, 1998; 64 FR 31973, June 15, 1999]

§ 416.421 Determination of benefits; computation of prorated benefits.

(a) In the month that you reacquire eligibility after a month or more of ineligibility (see § 416.1320(b)), your benefit will be prorated according to the number of days in the month that you

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(c) The agency must provide Medicaid eligibility in the same manner described in paragraph (a) of this section for a child born to an otherwise-eligible non-qualified alien woman so long as the woman has filed a complete Medicaid application (other than providing a social security number or demonstrating immigration status), including but not limited to meeting residency, income and resource requirements, has been determined eligible, is receiving Medicaid on the date of the child's birth, and remains (or would remain if pregnant) Medicaid eligible. All standard Medicaid application procedures apply, including timely determination of eligibility and adequate notice of the agency's decision concerning eligibility. A non-qualified alien receiving emergency medical services only under § 435.139 is considered to be Medicaid-eligible and receiving Medicaid for purposes of this provision. With respect to whether the mother remains (or would remain if pregnant) eligible for Medicaid after the birth of the child, the State must determine whether a non-qualified alien would remain eligible for emergency services under § 435.139. In determining whether the woman would remain eligible for these services, the State must consider whether the woman would remain eligible if pregnant. This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility.

(d) A redetermination of eligibility must be completed on behalf of the children described in this provision in accordance with the procedures at § 435.916. At that time, the State must collect documentary evidence of citizenship and identity as required under § 435.406.

[72 FR 38690, July 13, 2007]

MANDATORY COVERAGE OF QUALIFIED FAMILY MEMBERS

§ 435.119 Qualified family members.

(a) *Definition.* A *qualified family member* is any member of a family, including pregnant women and children eligible for Medicaid under § 435.116 of this subpart, who would be receiving AFDC cash benefits on the basis of the unemployment of the principal wage earner under section 407 of the Act had the State not chosen to place time limits on those benefits as permitted under section 407(b)(2)(B)(i) of the Act.

(b) *State plan requirement.* The State plan must provide that the State makes Medicaid available to any individual who meets the definition of "qualified family member" as specified in paragraph (a) of this section.

(c) *Applicability.* The provisions in this section are applicable in the 50 States and the District of Columbia from October 1, 1990, through September 30, 1998. The provisions are applicable in American Samoa from October 1, 1992, through September 30, 1998.

[58 FR 48614, Sept. 17, 1993]

MANDATORY COVERAGE OF THE AGED, BLIND, AND DISABLED

§ 435.120 Individuals receiving SSI.

Except as allowed under § 435.121, the agency must provide Medicaid to aged, blind, and disabled individuals or couples who are receiving or are deemed to be receiving SSI. This includes individuals who are—

(a) Receiving SSI pending a final determination of blindness or disability;

(b) Receiving SSI under an agreement with the Social Security Administration to dispose of resources that exceed the SSI dollar limits on resources; or

(c) Receiving benefits under section 1619(a) of the Act or in section 1619(b) status (blind individuals or those with disabling impairments whose income equals or exceeds a specific Supplemental Security Income limit). (Regulations at 20 CFR 416.260 through 416.269 contain requirements governing determinations of eligibility under this provision.) For purposes of this paragraph (c), this mandatory categorically needy group of individuals includes those qualified severely impaired individuals defined in section 1905(q) of the Act.

[55 FR 33705, Aug. 17, 1990]

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care an individual who is determined to be dependent (or would, if needy, be dependent) as specified in § 435.510; and

(6) Pregnant women.

(b) If the agency provides Medicaid to any individual in an optional group specified in paragraph (a) of this section, the agency must provide Medicaid to all individuals who apply and are found eligible to be members of that group.

(c) States that elect to use more restrictive eligibility requirements for Medicaid than the SSI requirements for any group or groups of aged, blind, and disabled individuals under § 435.121 must apply the specific requirements of § 435.230 in establishing eligibility of these groups of individuals as optional categorically needy.

[58 FR 4927, Jan. 19, 1993]

OPTIONS FOR COVERAGE OF FAMILIES AND CHILDREN AND THE AGED, BLIND, AND DISABLED

§ 435.210 Individuals who meet the income and resource requirements of the cash assistance programs.

The agency may provide Medicaid to any group or groups of individuals specified in § 435.201 (a)(1) through (a)(3) and (a)(5) and (a)(6) who are not mandatory categorically needy, who meet the income and resource requirements of the appropriate cash assistance program for their status (that is, the State's approved AFDC plan or SSI, or optional State supplements in States that provide Medicaid to optional State supplement recipients).

[58 FR 4927, Jan. 19, 1993]

§ 435.211 Individuals who would be eligible for cash assistance if they were not in medical institutions.

The agency may provide Medicaid to any group or groups of individuals specified in § 435.201(a) who are in title XIX reimbursable medical institutions and who:

(a) Are ineligible for the cash assistance program appropriate for their status (that is, AFDC or SSI, or optional State supplements in States that provide Medicaid to optional State supplement recipients) because of lower income standards used under the program to determine eligibility for institutionalized individuals; but

(b) Would be eligible for aid or assistance under the State's approved AFDC plan, SSI, or an optional State supplement as specified in §§ 435.232 and 435.234 if they were not institutionalized.

[58 FR 4927, Jan. 19, 1993]

§ 435.212 Individuals who would be ineligible if they were not enrolled in an MCO or PCCM.

The State agency may provide that a recipient who is enrolled in an MCO or PCCM and who becomes ineligible for Medicaid is considered to continue to be eligible—

(a) For a period specified by the agency, ending no later than 6 months from the date of enrollment; and

(b) Except for family planning services (which the recipient may obtain from any qualified provider) only for services furnished to him or her as an MCO enrollee.

[56 FR 8849, Mar. 1, 1991, as amended at 67 FR 41095, June 14, 2002]

§ 435.217 Individuals receiving home and community-based services.

The agency may provide Medicaid to any group or groups of individuals in the community who meet the following requirements:

(a) The group would be eligible for Medicaid if institutionalized.

(b) In the absence of home and community-based services under a waiver granted under part 441—

(1) Subpart G of this subchapter, the group would otherwise require the level of care furnished in a hospital, NF, or an ICF/MR; or

(2) Subpart H of this subchapter, the group would otherwise require the level of care furnished in an NF and are age 65 or older.

(c) The group receives the waivered services.

[57 FR 29155, June 30, 1992]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Agency*	Citation(s)	Groups Covered
IV-A		B. Optional Groups Other Than the Medically Needy
42 CFR 435.210 1902 (a) (10)(A)(ii) and 1905(a) of the Act	/X/1.	Individuals described below who meet the income and resources requirements of AFDC, SSI, or an optional state supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.
	/X/	The plan covers all individuals as described above.
	/ /	The plan covers only the following group or groups of individuals:
		___ Aged ___ Blind ___ Disabled ___ Caretaker relatives ___ Pregnant women
Section 1902 (V)(1) (42 U.S.C. 1396a)	/X/	The plan covers individuals not receiving SSI who the State finds blind or disabled and who are determined otherwise eligible for assistance during the period of time prior to which a final determination of disability or blindness is made by Social Security Administration. The State applies the definitions of disability and blindness found in Section 1614 (a) of the Social Security Act.
42 CFR 211 1902(a)(10)(A)(ii) + 1905(a) of the Act	/X/ 2.	Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

435.210
435.201(a)(3) & (b)

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*Agency that determines eligibility for coverage

[Code of Federal Regulations]
[Title 42, Volume 4]
[Revised as of October 1, 2008]
From the U.S. Government Printing Office via GPO Access
[CITE: 42CFR435.236]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 435_ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA--Table of Contents

Subpart C_Options for Coverage as Categorically Needy

Sec. 435.236 Individuals in institutions who are eligible under a special income level.

(a) If the agency provides Medicaid under Sec. 435.211 to individuals in institutions who would be eligible for AFDC, SSI, or State supplements except for their institutional status, it may also cover aged, blind, and disabled individuals in institutions who--

(1) Because of their income, would not be eligible for SSI or State supplements if they were not institutionalized; but

(2) Have income below a level specified in the plan under Sec. 435.722. (See Sec. 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section.)

(b) The agency may cover individuals under this section whether or not the State pays optional supplements.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980. Redesignated at 58 FR 4928, Jan. 19, 1993]

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
SSI 236			
42 CFR 435.231	/X/	12.	Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.
1902(a)(10)(A)(ii)(V) of the Act			
		/X/	The state covers all individuals as described above.
		/ /	The state covers only the following group or groups of individuals:
1902(a)(10)(A)(ii) and 1905(a) of the Act			___ Aged ___ Blind ___ Disabled ___ Individuals under the age of-- ___ 21 ___ 20 ___ 19 ___ 18 ___ Caretaker relatives ___ Pregnant women

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1 of 1 DOCUMENT

Earl Christy, Jr., Emelina Archuleta, on behalf of themselves and all others similarly situated, Plaintiffs-Appellants and Cross-Appellees, and Arcenio Chavez, David Howley, Ann Muth, Carol Salzer and Ella Turner, Plaintiffs-Intervenors-Appellants and Cross-Appellees, v. Irene Ibarra, individually and in her official capacity, and Colorado Department of Social Services, Defendants-Appellees and Cross-Appellants

No. 90CA2109

Court of Appeals of Colorado, Division Five

826 P.2d 361; 1991 Colo. App. LEXIS 252; 15 BTR 1156

August 15, 1991

SUBSEQUENT HISTORY: [**1] As Amended September 12, 1991. Rehearing Denied September 19, 1991. Certiorari Denied March 10, 1992 (91SC628). Released for Publication March 18, 1992.

PRIOR HISTORY: Appeal from the District Court of the City and County of Denver; Honorable Nancy Rice, Judge; No. 90CV4544.

DISPOSITION: JUDGMENT AFFIRMED IN PART, REVERSED IN PART, AND CAUSE REMANDED WITH DIRECTIONS

CASE SUMMARY:

PROCEDURAL POSTURE: Appellants, class of citizens, sought review of a decision of the District Court of the City and County of Denver, (Colorado) that dismissed a complaint against appellees, the Colorado Department of Social Services and its officials, in an action challenging its management of its Medicaid program.

OVERVIEW: The Colorado Department of Social Services (CDSS) failed to provide medical assistance to individuals in certain counties, as an alternative to institutional placement. A group of citizens filed suit after services to them were terminated by the CDSS because of the lack of management agencies in their respective counties of residence. The trial court found judgment for the CDSS and dismissed the citizens' complaint, ruling that Medicaid benefits did not need to be available in all counties of the state. The court reversed and remanded holding that it was incumbent upon the state to ensure case management services statewide and the designated case management agencies had an obligation to ensure that eligible recipients received care. 42 U.S.C.S. § 1396a(a)(1) required that a state plan for medical assistance be in effect in all political subdivisions of the state.

OUTCOME: The court reversed the dismissal of the citizens' class action challenging the CDSS's management of its Medicaid program.

CORE TERMS: eligible, recipient, statewide, Social Security Act, attorney fees, management services, general population, placement, medical assistance, remedial, provide services, delivery, medical treatment, state plan, required to provide, geographic area, cross-appeal, designation, cost-effective, optional, assuring, nursing

LexisNexis(R) Headnotes

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Public Health & Welfare Law > Social Security > Medicaid > General Overview

[HN1] Medicaid is a cooperative federal-state program that provides financial assistance to states to subsidize certain costs of

medical treatment for low-income individuals. Although participation in the Medicaid program is optional, once a state elects to participate, it must comply with the federal statutory scheme and the regulations promulgated by the Secretary of Health and Human Services.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Compliance
[HN2] 42 U.S.C.S. § 1396a(a)(1) provides that a state plan for medical assistance shall be in effect in all political subdivisions of the state. Federal regulation also requires that each state plan must be in operation statewide. 42 C.F.R. § 431.50(b)(1). A state may, pursuant to 42 C.F.R. § 431.50(c)(5), request that the Secretary of Health and Human Services waive the requirement of statewide compliance.

Public Health & Welfare Law > Social Security > Medicaid > General Overview
[HN3] Designation of management agencies is a function of the board of county commissioners in each county. The state may designate an agency if the board-appointed agency fails to meet the specified standards. When no agency is appointed, the state department may provide the management services directly. Colo. Rev. Stat. § 26-4-603(5).

Governments > Legislation > Interpretation
Public Health & Welfare Law > Social Security > Medicaid > General Overview
[HN4] The Social Security Act, of which Medicaid is a part, is in the nature of remedial legislation and is to be liberally construed. Narrow technicalities or a narrow and legalistic interpretation are to be avoided. And, interpretation should ensure that the overriding purpose will be achieved, even if the words used leave room for a contrary interpretation.

Public Health & Welfare Law > Social Security > Medicaid > General Overview
[HN5] If costs to maintain an individual out of an institution exceed the average state cost of an institutional placement, that individual is not eligible for HCBS (Home and Community Based Services) benefits. Colo. Rev. Stat. § 26-4-606(1)(d). Nevertheless, it is incumbent upon the state to ensure case management services statewide and the obligation of the designated case management agencies to ensure that eligible recipients receive care and services to the same extent as the general population in the geographic area.

COUNSEL: Doug George, Alamosa, Colorado; Dale L. Williams, Montrose, Colorado; Diane Flebbe, Greeley, Colorado; Daniel M. Taubman, Denver, Colorado for Plaintiffs-Appellants and Cross-Appellees and Plaintiffs-Intervenors-Appellants and Cross-Appellees.

Gale A. Norton, Attorney General, Raymond T. Slaughter, Chief Deputy Attorney General, Timothy M. Tymkovich, Solicitor General, David P. Temple, Assistant Attorney General, Denver, Colorado, for Defendant-Appellee and Cross-Appellant.

JUDGES: Opinion by Judge Ney. Plank and Van Cise, * JJ., concur.

* Sitting by assignment of the Chief Justice under provisions of the Colo. Const. art. VI, Sec. 5(3), and § 24-51-1105, C.R.S. (1988 Repl. Vol. 10B).

OPINION BY: NEY

OPINION

[*362] Plaintiffs, Earl Christy, Jr., and Emelina Archuleta, individually and on behalf of a class of persons similarly situated, and plaintiffs-intervenors, **[**2]** Arcenio Chavez, David Howley, Ann Muth, Carol Salzer, and Ella Turner, appeal the judgment of the court dismissing their complaint against defendants, Irene Ibarra and Colorado Department of Social Services. Defendants cross-appeal the trial court's denial of attorney fees. We reverse the judgment dismissing plaintiff's claims and affirm the trial court's denial of defendants' claim for attorney fees.

Plaintiffs are Colorado residents who are eligible for, but are not receiving, benefits under the Home and Community Based Services (HCBS) arm of the federal Medicaid healthcare program. HCBS provides cost-effective medical assistance to individuals as an alternative to institutional placement. Services provided range from skilled nursing and provision of medical supplies to performing routine household tasks. *See* § 26-4.5-104.5, C.R.S. (1989 Repl. Vol. 11B) (now codified as § 26-4-607(1), C.R.S. (1991 Cum. Supp.)).

Designation and delivery of services to be received is the result of an individual assessment of each applicant by the local case management agency. This agency develops and revises, as needed, each individual's care plan, monitors service

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delivery, [*363] and guarantees [**3] cost effectiveness. When no case management agency exists in an area, service is not provided even though eligible recipients are thereby denied receipt or continuation of benefits.

When services to plaintiffs were terminated because of the lack of management agencies in their respective counties of residence, this class action was brought seeking to compel the state to provide services to eligible recipients. The trial court concluded that the state had complied with the statutory mandate by developing a plan to provide services and had no duty to guarantee the actual delivery of services statewide nor to provide case management services. Therefore, it dismissed plaintiffs' complaint. This appeal followed.

I.

Plaintiffs first contend that the trial court erred in its conclusion that Medicaid benefits need not be available in all counties of the state, as required by 42 U.S.C. 1396a(a) (1984). We agree.

[HN1] Medicaid is a cooperative federal-state program that provides financial assistance to states to subsidize certain costs of medical treatment for low-income individuals. Although participation in the Medicaid program is optional, once a state elects to participate, it must comply [**4] with the federal statutory scheme and the regulations promulgated by the Secretary of Health and Human Services. *Harris v. McRae,* 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980); *Colorado Department of Social Services v. Health Care Management Consultants, Inc.,* 813 P.2d 829 (Colo. App. No. 89CA1979, June 6, 1991).

Section [HN2] 42 U.S.C. § 1396a(a)(1) (1984) provides that a state plan for medical assistance "shall be in effect in all political subdivisions of the state . . . ." Federal regulation also requires that each state plan must be "in operation statewide." 42 C.F.R. § 431.50(b)(1) (1990). A state may, pursuant to 42 C.F.R. § 431.50(c)(5) (1990), request that the Secretary of Health and Human Services waive the requirement of statewide compliance, but defendants have not done so here.

Defendants do not argue that they are not required to comply with these statutory directives. Rather, they assert that because the state has a plan to provide services statewide, its plan is "in effect" in accordance with the statute. We consider this contention to be without merit.

We find persuasive *Smith v. Vowell,* 379 F. Supp. 139 [**5] W.D. Tex (1974), *aff'd,* 504 F.2d 759 (5th Cir. 1974). In *Smith,* the state of Texas failed to provide Medicaid recipients with transportation to places of necessary medical treatment. The state advanced what the court characterized as "the preposterous argument that its only obligation under the regulation is merely a rhetorical one - that it only has to formulate a plan but not really put it into effect."

The state's position in *Smith* is analogous to defendants' argument here that because they have established procedures and requirements for certification of management agencies throughout the state, they have a plan in effect statewide. Defendants assume no responsibility for assuring that a management agency exists in each political subdivision, maintaining that the obligation to do so is optional.

While it is true that [HN3] designation of management agencies is a function of the board of county commissioners in each county, the state may designate an agency if the board-appointed agency fails to meet the specified standards. And, when no agency is appointed, the state department may provide the management services directly. *See* § 26-4.5-103(2), C.R.S. [**6] (1989 Repl. Vol. 11B) (now codified as § 26-4-603(5), C.R.S. (1991 Cum Supp.)).

However, should the state decline to fill the void created when no management agency exists in a county, services are not provided to eligible recipients. Thus, services are available in some counties and not available in the neighboring counties. And, a recipient in one county may lose benefits by moving a short distance across a county line. We conclude that this results in a plan to provide medical assistance which is not "in effect" statewide.

[*364] We agree with the court in *Smith, supra,* that:

"This court cannot conceive of any other meaning for 'be in effect' than its plain meaning that it shall be in existence, operational and functioning. . . We believe it to be essential to the proper interpretation of the Social Security Act to employ a natural reading which produces a harmonious result consistent with its legislative history and its remedial character. . . . The approach here advocated by defendants would simply make a mockery of the Social Security Act . . . ."

Similar results have been reached in *Clark v. Kizer,* Medicare-Medicaid Guide para. 38,880 (E.D. Cal. 1990) (state out of compliance with statewide availability provision when dental service not available in all counties) and *Morgan v. Cohen,* 665 F. Supp. 1164 (E.D. Pa. 1987) [**7] (under statewideness provision, services must operate uniformly across the state.)

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[HN4] The Social Security Act, of which Medicaid is a part, is in the nature of remedial legislation and is to be liberally construed. Narrow technicalities or a narrow and legalistic interpretation are to be avoided. *Schroeder v. Hobby,* 222 F.2d 713 (10th Cir. 1955). And, interpretation should ensure that the overriding purpose will be achieved, even if the words used leave room for a contrary interpretation. *Haberman v. Finch,* 418 F.2d 664 (2nd Cir. 1972).

To conclude that the obligation of the state ends prior to any actual service being delivered to eligible recipients is, thus, clearly contrary to the "remedial and beneficent purposes" for which the Social Security Act was enacted. *See Brown & Bartlett v. United States,* 330 F.2d 692 (6th Cir. 1964).

We do not, however, by this ruling that eligible recipients statewide must be provided with case management services, mean to imply that defendants are thereby required to provide *all* services to *all* eligible recipients. The obligation of the participating state is limited to providing permitted **[**8]** care and services only "to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)30(A) (1990). Accordingly, defendants are not required to provide, for example, adult day care services to eligible HCBS recipients if such services are not available to the general population.

To provide a cost-effective alternative to institutional placement implies that if required care cannot be obtained otherwise and is not available to the general population, placement in an institution may be necessary. In fact, [HN5] if costs to maintain an individual out of an institution exceed the average state cost of an institutional placement, that individual is not eligible for HCBS benefits. Section 26-4.5-104.5(3) C.R.S. (1989 Repl. Vol. 11B) (now codified at § 26-4-606(1)(d), C.R.S. (1991 Cum. Supp.)).

Nevertheless, it is incumbent upon the state to ensure case management services statewide and the obligation of the designated case management agencies to ensure that eligible recipients receive care and services to the same extent as the general population in the geographic area.

II.

Plaintiffs next assert that the trial court erred in failing **[**9]** to address their claims which were premised on violations of constitutional and statutory rights. We agree.

Plaintiffs alleged in their complaint that defendants failed to comply with:

42 U.S.C. § 1396a(a)(30)(A) by not assuring that Medicaid payments are sufficient to enlist the requisite number of service providers;

42 U.S.C. § 1396n(c)(2)(C) by not offering every HCBS eligible individuals the choice of nursing home or HCBS home care;

42 U.S.C. § 1396a(a)(8) by not establishing methods to guarantee services to all HCBS eligible recipients;

42 U.S.C. § 1396a(a)(19) by not providing benefits in the manner consistent with the best interests of each eligible recipient; and

[*365] constitutional and statutory guarantees of due process in the termination of benefits to eligible recipients.

Because the order of the trial court does not address these claims, we remand to that court for further consideration.

III.

Defendants contend on cross-appeal that the trial court erred in its denial of attorney fees under § 13-17-102(4), C.R.S. (1987 Repl. Vol. 6A). However, inasmuch as we have concluded that plaintiffs' claim regarding defendants' failure to have in effect a statewide **[**10]** plan is meritorious, it follows that the assertion of that claim was not frivolous. *See Montoya v. Bebensee,* 761 P.2d 285 (Colo. App. 1988).

The judgment dismissing plaintiffs' claims is reversed, the denial of defendants' claim for attorney fees is affirmed, and the cause is remanded for further proceedings consistent with this opinion.

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of termination of benefits, since (1) patients are not in position to claim any Fifth Amendment due process protection where loss of benefits was only indirectly caused by Secretary's decision to decertify hospital, (2) Congress acted rationally in separately classifying and certifying psychiatric hospitals, thus requiring stricter standards for certification of psychiatric hospitals, and (3) it was not irrational for Congress to decide that government will not bankroll local efforts to provide medical care when it has been determined that those services are insufficient. Cospito v Heckler (1984, CA3 NJ) 742 F2d 72, cert den (1985) 471 US 1131, 86 L Ed 2d 282, 105 S Ct 2665.

For purposes of determining whether disability benefits should be terminated, benefits provider was required to answer question of claimant's condition at time of cessation determination based on all of evidence available in individual's case file; since trial court disregarded post-cessation evidence that claimant was disabled due to back condition arising from treatment in month before cessation date, trial court erred in granting summary judgment to benefits provider and remand was required for further proceedings. McNabb v Barnhart (2003, CA9 Cal) 340 F3d 943, 90 Soc Sec Rep Serv 259, 2003 CDOS 7562, CCH Unemployment Ins Rep ¶ 17070B.

When state reduces or terminates aid to dependent children or aid to aged, blind and disabled without notice and without hearing, in violation of federal regulations, substantial constitutional question arises over which federal district court has jurisdiction. Serritella v Engelman (1972, DC NJ) 339 F Supp 738, 15 FR Serv 2d 1212.

State practice of reducing or terminating excess prescribed medicine grants under Medicaid program without prior notice and opportunity to be heard violates Social Security Act (former 42 USCS § 1382(a)(4)) and regulation promulgated pursuant to 42 USCS § 1302. Silvey v Roberts (1973, MD Fla) 363 F Supp 1006.

27. Miscellaneous

Question of whether individual had excess resources that rendered him ineligible for SSI benefits is mixed question of law and fact. White v Apfel (1999, CA7 Ill) 167 F3d 369, 60 Soc Sec Rep Serv 103.

Where district court, after appropriate inquiry into particular circumstances of matter at hand, determines that non-attorney parent who brings SSI appeal on behalf of his children has sufficient interest in case and meets basic standards of competence, then non-attorney parent may bring pro se action on behalf of his children appealing administrative denial of SSI benefits. Machadio v Apfel (2002, CA2 NY) 276 F3d 103, 77 Soc Sec Rep Serv 559, CCH Unemployment Ins Rep ¶ 16691B.

Class action could be maintained, in respect to declaratory or injunctive relief if not as to damages, to contest validity of cessation of benefits not in accord with HEW [now SSA] fair hearing regulation. Fischer v Weaver (1972, ND Ill) 55 FRD 454, 16 FR Serv 2d 247.

In accordance with 20 CFR § 416.330, SSI application remains in effect only until issuance of ALJ's decision, not throughout appeals process, notwithstanding policy statement in POMS § DI 27510.015(A), stating that both OASDI and SSI applications remain valid throughout appeals process. Young v Sullivan (1989, ND Ill) 1989 US Dist LEXIS 11070.

Commissioner of Social Security Administration's decision that claimant was not entitled to social security disability insurance and supplemental security income was affirmed where administrative law judge did not err by adopting consultative opinion of non-treating physician because his opinion was supported by objective medical evidence, including evidence provided by claimant's treating and examining physicians, and was not inconsistent with other medical evidence of record; opinions of claimant's treating physicians were, for most part, based on claimant's own descriptions of pain and lack of objective medical findings. Reeves v Barnhart (2003, DC Mass) 263 F Supp 2d 154, 89 Soc Sec Rep Serv 57.

Commissioner of Social Security Administration's decision that claimant was not entitled to social security disability insurance and supplemental security income was affirmed where administrative law judge (ALJ) did not fail to properly evaluate claimant's subjective complaints of pain; ALJ explicitly questioned claimant concerning Avery factors and gave specific reasons for her findings; claimant's testimony that she led very active lifestyle, together with objective medical testimony, was found by ALJ to be inconsistent with claimant's subjective complaints of pain and provided substantial evidence to support ALJ's credibility assessment. Reeves v Barnhart (2003, DC Mass) 263 F Supp 2d 154, 89 Soc Sec Rep Serv 57.

§ 1382a. Income; earned and unearned income defined; exclusions from income

(a) For purposes of this title [42 USCS §§ 1381 et seq.], income means both earned income and unearned income; and—

(1) earned income means only—

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(A) wages as determined under section 203(f)(5)(C) [42 USCS § 403(f)(5)(C)] but without the application of section 210(j)(3) [42 USCS § 410(j)(3)];

(B) net earnings from self-employment, as defined in section 211 [42 USCS § 411] (without the application of the second and third sentences following subsection (a)(11), the last paragraph of subsection (a), and section 210(j)(3) [42 USCS § 410(j)(3)]), including earnings for services described in paragraphs (4), (5), and (6) of subsection (c);

(C) remuneration received for services performed in a sheltered workshop or work activities center; and

(D) any royalty earned by an individual in connection with any publication of the work of the individual, and that portion of any honorarium which is received for services rendered; and

(A) (2) unearned income means all other income, including—

(A) support and maintenance furnished in cash or kind; except that (i) in the case of any individual (and his eligible spouse, if any) living in another person's household and receiving support and maintenance in kind from such person, the dollar amounts otherwise applicable to such individual (and spouse) as specified in subsections (a) and (b) of section 1611 [42 USCS § 1382(a) and (b)] shall be reduced by 33⅓ percent in lieu of including such support and maintenance in the unearned income of such individual (and spouse) as otherwise required by this subparagraph and (ii) in the case of any individual or his eligible spouse who resides in a nonprofit retirement home or similar nonprofit institution, support and maintenance shall not be included to the extent that it is furnished to such individual or such spouse without such institution receiving payment therefor (unless such institution has expressly undertaken an obligation to furnish full support and maintenance to such individual or spouse without any current or future payment therefor) or payment therefor is made by another nonprofit organization, and (iii) support and maintenance shall not be included and the provisions of clause (i) shall not be applicable in the case of any individual (and his eligible spouse, if any) for the period which begins with the month in which such individual (or such individual and his eligible spouse) began to receive support and maintenance while living in a residential facility (including a private household) maintained by another person and ends with the close of the month in which such individual (or such individual and his eligible spouse) ceases to receive support and maintenance while living in such a residential facility (or, if earlier, with the close of the seventeenth month following the month in which such period began), if, not more than 30 days prior to the date on which such individual (or such individual and his eligible spouse) began to receive support and maintenance while living in such a residential facility, (I) such individual (or such individual and his eligible spouse) were residing in a household maintained by such individual (or by such individual and others) as his or their own home, (II) there occurred within the area in which such household is located (and while such individual, or such individual and his spouse, were residing in the household referred

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to in subclause (I) a catastrophe on account of which the President declared a major disaster to exist therein for purposes of the Disaster Relief and Emergency Assistance Act, and (III) such individual declares that he (or he and his eligible spouse) ceased to continue living in the household referred to in subclause (II) because of such catastrophe;

(B) any payments received as an annuity, pension, retirement, or disability benefit, including veterans' compensation and pensions, workmen's compensation payments, old-age, survivors, and disability insurance benefits, railroad retirement annuities and pensions, and unemployment insurance benefits;

(C) prizes and awards;

(D) payments to the individual occasioned by the death of another person, to the extent that the total of such payments exceeds the amount expended by such individual for purposes of the deceased person's last illness and burial;

(E) support and alimony payments, and (subject to the provisions of subparagraph (D) excluding certain amounts expended for purposes of a last illness and burial) gifts (cash or otherwise) and inheritances;

(F) rents, dividends, interest, and royalties not described in paragraph (1)(E); and

(G) any earnings of, and additions to, the corpus of a trust established by an individual (within the meaning of section 1613(e) [42 USCS § 1382b(e)]), of which the individual is a beneficiary, to which section 1613(e) [42 USCS § 1382b(e)] applies, and, in the case of an irrevocable trust, with respect to which circumstances exist under which a payment from the earnings or additions could be made to or for the benefit of the individual.

(b) In determining the income of an individual (and his eligible spouse) there shall be excluded—

(1) **[Caution: For provisions in effect with respect to benefits payable for months that begin before March 2, 2005, see note below describing the amendment made to this paragraph by Act March 2, 2004.]** subject to limitations (as to amount or otherwise) prescribed by the Commissioner of Social Security, if such individual is under the age of 22 and is, as determined by the Commissioner of Social Security, a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment, the earned income of such individual;

(2)(A) the first $240 per year (or proportionately smaller amounts for shorter periods) of income (whether earned or unearned) other than income which is paid on the basis of the need of the eligible individual, and

(B) monthly (or other periodic) payments received by any individual, under a program established prior to July 1, 1973 (or any program established prior to such date but subsequently amended so as to conform to State or Federal constitutional standards), if (i) such payments are made by the State of which the individual receiving such payments is a resident,

(ii) eligibility of any individual for such payments is not based on need and is based solely on attainment of age 65 or any other age set by the State and residency in such State by such individual, and (iii) on or before September 30, 1985, such individual (I) first becomes an eligible individual or an eligible spouse under this title [42 USCS §§ 1381 et seq.], and (II) satisfies the twenty-five-year residency requirement of such program as such program was in effect prior to January 1, 1983;

(3) in any calendar quarter, the first—

(A) $60 of unearned income, and

(B) $30 of earned income,

of such individual (and such spouse, if any) which, as determined in accordance with criteria prescribed by the Commissioner of Social Security, is received too infrequently or irregularly to be included;

(4)(A) if such individual (or such spouse) is blind (and has not attained age 65, or received benefits under this title [42 USCS §§ 1381 et seq.] (or aid under a State plan approved under section 1002 or 1602 [42 USCS §§ 1202 or 1382 note]) for the month before the month in which he attained age 65), (i) the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof, (ii) an amount equal to any expenses reasonably attributable to the earning of any income, and (iii) such additional amounts of other income, where such individual has a plan for achieving self-support approved by the Commissioner of Social Security, as may be necessary for the fulfillment of such plan,

(B) if such individual (or such spouse) is disabled but not blind (and has not attained age 65, or received benefits under this title [42 USCS §§ 1381 et seq.] (or aid under a State plan approved under section 1402 or 1602 [42 USCS §§ 1352 or 1382 note]) for the month before the month in which he attained age 65), (i) the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, (ii) such additional amounts of earned income of such individual, if such individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, as may be necessary to pay the costs (to such individual) of attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions, except that the amounts to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe, (iii) one-half of the amount of earned income not excluded after the application of the preceding provisions of this subparagraph, and (iv) such additional amounts of other income, where such individual has a plan for achieving self-support approved by the Commis-

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sioner of Social Security, as may be necessary for the fulfillment of such plan, or

(C) if such individual (or such spouse) has attained age 65 and is not included under subparagraph (A) or (B), the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof;

(5) any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased by such individual (or such spouse);

(6) assistance, furnished to or on behalf of such individual (and spouse), which is based on need and furnished by any State or political subdivision of a State;

(7) any portion of any grant, scholarship, fellowship, or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational (including technical or vocational education) institution;

(8) home produce of such individual (or spouse) utilized by the household for its own consumption;

(9) if such individual is a child, one-third of any payment for his support received from an absent parent;

(10) any amounts received for the foster care of a child who is not an eligible individual but who is living in the same home as such individual and was placed in such home by a public or nonprofit private child-placement or child-care agency;

(11) assistance received under the Disaster Relief Act of 1974 [42 USCS §§ 5121 et seq.] or other assistance provided pursuant to a Federal statute on account of a catastrophe which is declared to be a major disaster by the President;

(12) interest income received on assistance funds referred to in paragraph (11) within the 9-month period beginning on the date such funds are received (or such longer periods as the Commissioner of Social Security shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period);

(13) any assistance received to assist in meeting the costs of home energy, including both heating and cooling, which (as determined under regulations of the Commissioner of Social Security by such State agency as the chief executive officer of the State may designate) (A) is based on need for such assistance, and (B) is (i) assistance furnished in kind by a private nonprofit agency, or (ii) assistance furnished by a supplier of home heating oil or gas, by an entity providing home energy whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity, or by a municipal utility providing home energy;

(14) assistance paid, with respect to the dwelling unit occupied by such individual (or such individual and spouse), under the United States Housing Act of 1937 [42 USCS §§ 1401 et seq.], the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, title V of the

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Housing Act of 1949 [42 USCS §§ 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 USCS § 1701q(h)];

(15) the value of any commercial transportation ticket, for travel by such individual (or spouse) among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by such individual (or such spouse) and is not converted to cash;

(16) interest accrued on the value of an agreement entered into by such individual (or such spouse) representing the purchase of a burial space excluded under section 1613(a)(2)(B) [42 USCS § 1382b(a)(2)(B)], and left to accumulate;

(17) any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime; and

(18) relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act [42 USCS § 4636];

(19) any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 [26 USCS § 32] (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code [26 USCS § 3507] (relating to advance payment of earned income credit);

(20) special pay received pursuant to section 310 of title 37, United States Code;

(21) the interest or other earnings on any account established and maintained in accordance with section 1631(a)(2)(F) [42 USCS § 1383(a)(2)(F)];

(22) any gift to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition, from an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(3)] which is exempt from taxation under section 501(a) of such Code [26 USCS § 501(a)]—

(A) in the case of an in-kind gift, if the gift is not converted to cash; or

(B) in the case of a cash gift, only to the extent that the total amount excluded from the income of the individual pursuant to this paragraph in the calendar year in which the gift is made does not exceed $2,000; and

(23) interest or dividend income from resources—

(A) not excluded under section 1613(a) [42 USCS § 1382b(a)], or

(B) excluded pursuant to Federal law other than section 1613(a) [42 USCS § 1382b(a)].

(Aug. 14, 1935, ch 531, Title XVI, Part A, § 1612, as added Oct. 30, 1972, P. L. 92-603, Title III, § 301, 86 Stat. 1468; Oct. 26, 1974, P. L. 93-484, § 4, 88 Stat. 1460; Jan. 2, 1976, P. L. 94-202, § 9, 89 Stat. 1140; June 30, 1976, P. L. 94-331, §§ 2(a), 4(a), 90 Stat. 781, 782; Oct. 4, 1976, P. L. 94-455, § 2125, 90 Stat. 1920; Oct. 20, 1976, P. L. 94-566, Title V, § 505(b), 90 Stat.

2686; Nov. 12, 1977, P. L. 95-171, § 8(a), 91 Stat. 1355; April 1, 1980, P. L. 96-222, Title I, § 101(a)(2)(B), 94 Stat. 195; June 9, 1980, P. L. 96-265, Title II, § 202(a), Title III, § 302(b), 94 Stat. 449, 451; Oct. 19, 1980, P. L. 96-473, Title, § 6(g), 94 Stat. 2266; Aug. 13, 1981, P. L. 97-35, Title XXIII, Subtitle H, § 2341(b), 95 Stat. 865; Jan. 6, 1983, P. L. 97-424, Title V, Subtitle E, § 545(a), 96 Stat. 2198; April 20, 1983, P. L. 98-21, Title IV, § 404(a), 97 Stat. 140; July 18, 1984, P. L. 98-369, Division B, Title VI, Subtitle B, Part 1, § 2616(a), Part 2, § 2639(b), (c), Subtitle D, § 2663(g)(3)(4), 98 Stat. 1133, 1144, 1168; Oct. 22, 1986, P. L. 99-514, Title XVIII, Subtitle B, Ch 1, § 1883(d)(2), (3), 100 Stat. 2918; Dec. 22, 1987, P. L. 100-203, Title IX, Subtitle B, Part 1, § 9120(a), 101 Stat. 1330-309; Nov. 10, 1988, P. L. 100-647, Title VIII, Subtitle B, § 8103(a), 102 Stat. 3795; Nov. 23, 1988, P. L. 100-707, Title I, § 109(p), 102 Stat. 4709; Dec. 19, 1989, P. L. 101-239, Title VIII, § 8011(a), 8013(a) 103 Stat. 2464; Nov. 5, 1990, P. L. 101-508, Title V, Subtitle A, Ch 3, §§ 5031(a), 5033(a), 5034(a), 5035(a), Title XI, Subtitle A, Part II, § 11115(b)(1), 104 Stat. 1388-224, 1388-225, 1388-414; Aug. 10, 1993, P. L. 103-66, Title XIII, Ch 2, Subch C, Part III, § 13733(b), 107 Stat. 662; Aug. 15, 1994, P. L. 103-296, Title I, § 107(a)(4), 108 Stat. 1478; Oct. 31, 1994, P. L. 103-432, Title II, Subtitle F, §§ 264(a), 267(a), 108 Stat. 4467, 4469; Aug. 22, 1996, P. L. 104-193, Title II, Subtitle B, § 213(c), 110 Stat. 2195; Oct. 28, 1998, P. L. 105-306, § 7(a), 112 Stat. 2928; Dec. 14, 1999, P. L. 106-169, Title II, Subtitle A, § 205(b), 113 Stat. 1834; Dec. 21, 2000, P. L. 106-554, § 1(a)(1), 114 Stat. 2763; March 2, 2004, P. L. 108-203, Title IV, Subtitle D, §§ 430(a), (b), 432(a), 435(a), 118 Stat. 538, 539, 540.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

References in text:

The "Disaster Relief and Emergency Assistance Act", also known as the "Robert T. Stafford Disaster Relief and Emergency Assistance Act", referred to in subsecs. (a)(2)(A) and (b)(11), is Act May 22, 1974, P. L. 93-288, which appears generally as 42 USCS §§ 5121 et seq. For full classification of such Act, consult USCS Tables volumes.

The "National Housing Act", referred to in subsec. (b)(14), is Act June 27, 1934, ch 847, which appears generally as 12 USCS §§ 1701 et seq. For full classification of such Act, consult USCS Tables volumes.

"Section 101 of the Housing and Urban Development Act of 1965", referred to in subsec. (b)(14), is § 101 of Act Aug. 10, 1965, P. L. 89-117, which amended 12 USCS § 1701s and 42 USCS § 1451 and repealed 42 USCS § 1465.

"Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970", referred to in subsec. (b)(18), is Title II of Act Jan. 2, 1971, P. L. 91-646, which appears generally as 42 USCS §§ 4621 et seq. For full classification of such Title, consult USCS Tables volumes.

In redesignating the Internal Revenue Code of 1954 as the Internal Revenue Code of 1986, Congress provided, in Act Oct. 22, 1986, P. L. 95-514, § 2, 100 Stat. 2095, for construction of references to the Internal Revenue Code as follows: except when inappropriate, any reference in any law, Executive Order, or other document to the Internal Revenue Code of 1954 shall

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reasons for claimant's discrediting subjective complaints; thus, ALJ did not properly determine if claimant proved that she was unable to perform substantial gainful activity under 42 USCS §§ 423(a)(1)(D), (d)(1)(A), and 1382c(a)(3)(A). Gramlisch v Barnhart (2006, ED Mo) 464 F Supp 2d 876.

Denial of benefits claimant's application for period of disability, 42 USCS § 416(i)(2)(A), disability insurance benefits, 42 USCS § 423, and supplemental security income benefits, 42 USCS § 1382, was affirmed because, as required by 42 USCS § 405(g), substantial evidence supported hearing officer's decision that benefits claimant was not disabled as there were sedentary jobs that she could perform despite her impairments, and hearing officer followed proper standards for evaluating claimant's back pain. Hardin v Barnhart (2006, DC Mass) 468 F Supp 2d 238.

In action in which social security claimant sought review, pursuant to 42 USCS §§ 405(g) and 1381, of final decision of Commissioner of Social Security denying claimant's application for disability insurance benefits and supplemental security income under 42 USCS §§ 401–433, 1381–1383f, Commissioner's decision was affirmed where: (1) although administrative law judge (ALJ) did not find that claimant's fibromyalgia was severe impairment, ALJ did not deny benefits at this stage of evaluation and continued on to step five considering other impairments whose affects on claimant were essentially same as those that would have been found if ALJ had found that claimant's fibromyalgia was severe; (2) ALJ's evaluation of claimant's subjective complaints of pain was supported by substantial evidence; and (3) although treating physician was claimant's family physician, he was not specialist and none of specialists who treated claimant opined that claimant was so severely limited as to be disabled. Thomas v Barnhart (2007, DC Del) 469 F Supp 2d 228.

26. Review of termination or reduction of benefits

Termination of supplemental security income childhood disability benefits under Social Security Act, 42 USCS § 1382, was affirmed where law followed in originally determining that child was disabled was incorrect when there was no medical evidence to support finding and child's mother was uncooperative with continuing disability review. Mason v Barnhart (2003, ED NY) 86 Soc Sec Rep Serv 410.

Court remanded pro se social security claimant's action challenging final determination of Commissioner of Social Security that her disability ceased as of March 1999 for further development of record where (1) although ALJ discussed claimant's hospital records in great detail in his decision, he failed to obtain updated residual functional capacity (RFC) assessments; (2) ALJ fell short by failing to advise claimant of importance of her treating physician's RFC assessment; and (3) progress notes pre-dating January 23, 2002, should be considered on remand. Batista v Barnhart (2004, ED NY) 326 F Supp 2d 345, 99 Soc Sec Rep Serv 200.

27. Miscellaneous

Where recipient's benefits were suspended after he was indicted by foreign state grand jury for felony larceny and for making false material statement on voter registration form, remand was required because, under plain language of 42 USCS § 1382(e)(4))(A) and its implementing regulation, 20 C.F.R. § 416.1339(b)(1), in order to suspend benefits for being fugitive felon, there had to be proof of intent to flee and warrant issued by court indicating that individual had fled from justice. Fowlkes v Adamec (2005, CA2 NY) 432 F3d 90.

In action in which Commissioner of Social Security appealed from judgment of district court which reversed decision denying claimant's application for disability insurance benefits and supplemental security income under Social Security Act and remanded for entry of award of benefits, judgment was reversed, and case was remanded for entry of judgment for Commissioner where (1) there was substantial evidence that claimant exaggerated or invented his physical ailments, and that any genuine impairments were slight; (2) claimant underwent several rounds of diagnostic testing to determine cause of tremors, all of which produced normal results; and (3) substantial evidence supported administrative law judge's finding that claimant did not suffer significant impairment because of his psychiatric illness as claimant's claims of psychiatric problems had always been vague. Kirby v Astrue (2007, CA8 Mo) 500 F3d 705.

§ 1382a. Income; earned and unearned income defined; exclusions from income

INTERPRETIVE NOTES AND DECISIONS

II. SOURCES OF INCOME

23. Other resources

Stipend paid from supplemental needs trust to Supplemental Security Income claimant's parent was properly deemed to claimant, resulting in reduction of benefits; stipend was unearned income, as claimant did not employ parent. Calef v Barnhart (2004, ED NY) 309 F Supp 2d 425, 96 Soc Sec Rep Serv 281.

§ 1382c. Definitions

RESEARCH GUIDE

Federal Procedure:

30 Fed Proc L Ed, Social Security and Medicare §§ 71:193, 230, 236, 240, 283, 286.

Immigration:

1 Immigration Law and Procedure (rev. ed.), ch 6, Aliens' Rights, Privileges and Liabilities § 6.07.

4 Immigration Law and Procedure (rev. ed.), ch 52, Legalization § 52.05.

4 Immigration Law and Procedure (rev. ed.), ch 55, Visa Processing § 55.05.

Law Review Articles:

Rains. Disability And Family Relationships: Marriage Penalties and Support Anomalies. 22 Ga St U L Rev 561, Spring 2006.

§ 416.1092 Protection of State employees.

(a) *Hiring preference.* We will develop and initiate procedures to implement a plan to partially or completely assume the disability determination function from the State agency under § 416.1090 or § 416.1091, as appropriate. Except for the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent), we will give employees of the State agency who are capable of performing duties in the disability determination function preference over any other persons in filling positions with us for which they are qualified. We may also give a preference in hiring to the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent). We will establish a system for determining the hiring priority among the affected State agency employees in those instances where we are not hiring all of them.

(b) *Determination by Secretary of Labor.* We will not assume responsibility for performing the disability determination function from a State until the Secretary of Labor determines that the State has made fair and equitable arrangements under applicable Federal, State and local law to protect the interests of employees who will be displaced from their employment because of the assumption and who we will not hire.

§ 416.1093 Limitation on State expenditures after notice.

The State agency may not, after it receives the notice referred to in § 416.1090, or gives the notice referred to in § 416.1091, make any new commitments to spend funds allocated to it for performing the disability determination function without the approval of the appropriate SSA regional commissioner. The State will make every effort to close out as soon as possible all existing commitments that relate to performing the disability determination function.

§ 416.1094 Final accounting by the State.

The State will submit its final claims to us as soon as possible, but in no event later than 1 year from the effective date of our assumption of the disability determination function unless we grant an extension of time. When the final claim(s) is submitted, a final accounting will be made by the State of any funds paid to the State under § 416.1026 which have not been spent or committed prior to the effective date of our assumption of the disability determination function. Disputes concerning final accounting issues which cannot be resolved between the State and us will be resolved in proceedings before the Grant Appeals Board as described in 45 CFR part 416.

Subpart K—Income

AUTHORITY: Secs. 702(a)(5), 1602, 1611, 1612, 1613, 1614(f), 1621, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, 1383, and 1383b); sec. 211, Pub. L. 93–66, 87 Stat. 154 (42 U.S.C. 1382 note).

SOURCE: 45 FR 65547, Oct. 3, 1980, unless otherwise noted.

GENERAL

§ 416.1100 Income and SSI eligibility.

You are eligible for supplemental security income (SSI) benefits if you are an aged, blind, or disabled person who meets the requirements described in subpart B and who has limited income and resources. Thus, the amount of income you have is a major factor in deciding whether you are eligible for SSI benefits and the amount of your benefit. We count income on a monthly basis. Generally, the more income you have the less your benefit will be. If you have too much income, you are not eligible for a benefit. However, we do not count all of your income to determine your eligibility and benefit amount. We explain in the following sections how we treat your income for the SSI program. These rules apply to the Federal benefit and to any optional State supplement paid by us on behalf of a State (§ 416.2025) except as noted in subpart T and in the Federal-State agreements with individual States. While this subpart explains how we count income, subpart D of these regulations explains how we determine your benefits, including the provision

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that we generally use countable income in a prior month to determine how much your benefit amount will be for a month in which you are eligible (§ 416.420).

[50 FR 48573, Nov. 26, 1985]

§ 416.1101 Definition of terms.

As used in this subpart—

Calendar quarter means a period of three full calendar months beginning with January, April, July, or October.

Child means someone who is not married, is not the head of a household, and is either under age 18 or is under age 22 and a student. (See § 416.1856)

Couple means an eligible individual and his or her eligible spouse.

Current market value means the price of an item on the open market in your locality.

Federal benefit rate means the monthly payment rate for an eligible individual or couple. It is the figure from which we substract countable income to find out how much your Federal SSI benefit should be. The Federal benefit rate does not include the rate for any State supplement paid by us on behalf of a State.

Institution means an establishment which makes available some treatment or services beyond food and shelter to four or more persons who are not related to the proprietor. (See § 416.201)

Spouse means someone who lives with another person as that person's husband or wife. (See § 416.1806)

We, Us, or *Our* means the Social Security Administration.

You or *Your* means a person who is applying for, or already receiving, SSI benefits.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48573, Nov. 26, 1985; 51 FR 10616, Mar. 28, 1986; 60 FR 16375, Mar. 30, 1995]

§ 416.1102 What is income?

Income is anything you receive in cash or in kind that you can use to meet your needs for food and shelter. Sometimes income also includes more or less than you actually receive (see § 416.1110 and § 416.1123(b)). In-kind income is not cash, but is actually food or shelter, or something you can use to get one of these.

[70 FR 6344, Feb. 7, 2005]

§ 416.1103 What is not income?

Some things you receive are not income because you cannot use them as food or shelter, or use them to obtain food or shelter. In addition, what you receive from the sale or exchange of your own property is not income; it remains a resource. The following are some items that are not income:

(a) *Medical care and services.* Medical care and services are not income if they are any of the following:

(1) Given to you free of charge or paid for directly to the provider by someone else;

(2) Room and board you receive during a medical confinement;

(3) Assistance provided in cash or in kind (including food or shelter) under a Federal, State, or local government program whose purpose is to provide medical care or medical services (including vocational rehabilitation);

(4) In-kind assistance (except food or shelter) provided under a nongovernmental program whose purpose is to provide medical care or medical services;

(5) Cash provided by any nongovernmental medical care or medical services program or under a health insurance policy (except cash to cover food or shelter) if the cash is either:

(i) Repayment for program-approved services you have already paid for; or

(ii) A payment restricted to the future purchase of a program-approved service.

Example: If you have paid for prescription drugs and get the money back from your health insurance, the money is not income.

(6) Direct payment of your medical insurance premiums by anyone on your behalf.

(7) Payments from the Department of Veterans Affairs resulting from unusual medical expenses.

(b) *Social services.* Social services are not income if they are any of the following:

(1) Assistance provided in cash or in kind (but not received in return for a service you perform) under any Federal, State, or local government program whose purpose is to provide social services including vocational rehabilitation (Example: Cash given you by the

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Department of Veterans Affairs to purchase aid and attendance);

(2) In-kind assistance (except food or shelter) provided under a nongovernmental program whose purpose is to provide social services; or

(3) Cash provided by a nongovernmental social services program (except cash to cover food or shelter) if the cash is either:

(i) Repayment for program-approved services you already have paid for; or

(ii) A payment restricted to the future purchase of a program-approved service.

Example: If you are unable to do your own household chores and a private social services agency provides you with cash to pay a homemaker the cash is not income.

(c) *Receipts from the sale, exchange, or replacement of a resource.* Receipts from the sale, exchange, or replacement of a resource are not income but are resources that have changed their form. This includes any cash or in-kind item that is provided to replace or repair a resource (see subpart L) that has been lost, damaged, or stolen. Sections 416.1150 and 416.1151 discuss treatment of receipts to replace or repair a resource following a major disaster or following some other event causing damage or loss of a resource.

Example: If you sell your automobile, the money you receive is not income; it is another form of a resource.

(d) *Income tax refunds.* Any amount refunded on income taxes you have already paid is not income.

(e) *Payments by credit life or credit disability insurance.* Payments made under a credit life or credit disability insurance policy on your behalf are not income.

Example: If a credit disability policy pays off the mortgage on your home after you become disabled in an accident, we do not consider either the payment or your increased equity in the home to be income.

(f) *Proceeds of a loan.* Money you borrow or money you receive as repayment of a loan is not income. However, interest you receive on money you have lent is income. Buying on credit is treated as though you were borrowing money and what you purchase this way is not income.

(g) *Bills paid for you.* Payment of your bills by someone else directly to the supplier is not income. However, we count the value of anything you receive because of the payment if it is in-kind income as defined in § 416.1102.

Examples: If your daughter uses her own money to pay the grocer to provide you with food, the payment itself is not your income because you do not receive it. However, because of your daughter's payment, the grocer provides you with food; the food is in-kind income to you. Similarly, if you buy food on credit and your son later pays the bill, the payment to the store is not income to you, but the food is in-kind income to you. In this example, if your son pays for the food in a month after the month of purchase, we will count the in-kind income to you in the month in which he pays the bill. On the other hand, if your brother pays a lawn service to mow your grass, the payment is not income to you because the mowing cannot be used to meet your needs for food or shelter. Therefore, it is not in-kind income as defined in § 416.1102.

(h) *Replacement of income you have already received.* If income is lost, destroyed, or stolen and you receive a replacement, the replacement is not income.

Example: If your paycheck is stolen and you get a replacement check, we count the first check as income. The replacement check is not income.

(i) *Weatherization assistance.* Weatherization assistance (Examples: Insulation, storm doors and windows) is not income.

(j) *Receipt of certain noncash items.* Any item you receive (except shelter as defined in § 416.1130 or food) which would be an excluded nonliquid resource (as described in subpart L of this part) if you kept it, is not income.

Example 1: A community takes up a collection to buy you a specially equipped van, which is your only vehicle. The value of this gift is *not income* because the van does not provide you with food or shelter and will become an excluded nonliquid resource under § 416.1218 in the month following the month of receipt.

Example 2: You inherit a house which is your principal place of residence. The value of this inheritance *is* income because the house provides you with shelter and shelter

is income. However, we value the house under the rule in § 416.1140.

[45 FR 65547, Oct. 3, 1980, as amended at 49 FR 48038, Dec. 10, 1984; 57 FR 53850, Nov. 13, 1992; 59 FR 33907, July 1, 1994; 70 FR 6344, Feb. 7, 2005]

§ 416.1104 Income we count.

We have described generally what income is and is not for SSI purposes (§ 416.1103). There are different types of income, earned and unearned, and we have rules for counting each. The earned income rules are described in §§ 416.1110 through 416.1112 and the unearned income rules are described in §§ 416.1120 through 416.1124. One type of unearned income is in-kind support and maintenance (food or shelter). The way we value it depends on your living arrangement. These rules are described in §§ 416.1130 through 416.1148 of this part. In some situations we must consider the income of certain people with whom you live as available to you and part of your income. These rules are described in §§ 416.1160 through 416.1169. We use all of these rules to determine the amount of your countable income—the amount that is left after we subtract what is not income or is not counted.

[45 FR 65547, Oct. 3, 1980, as amended at 65 FR 16815, Mar. 30, 2000; 70 FR 6345, Feb. 7, 2005]

Earned Income

§ 416.1110 What is earned income.

Earned income may be in cash or in kind. We may include more of your earned income than you actually receive. We include more than you actually receive if amounts are withheld from earned income because of a garnishment or to pay a debt or other legal obligation, or to make any other payments. Earned income consists of the following types of payments:

(a) *Wages.* Wages are what you receive (before any deductions) for working as someone else's employee. Wages are the same for SSI purposes as for the earnings test in the social security retirement program. (See § 404.429(c) of this chapter.) Wages include salaries, commissions, bonuses, severance pay, and any other special payments received because of your employment. They may also include the value of food, clothing, or shelter, or other items provided instead of cash. We refer to this as in-kind earned income. However, if you are a domestic or agricultural worker, the law requires us to treat your in-kind pay as unearned income.

(b) *Net earnings from self-employment.* Net earnings from self-employment are your gross income from any trade or business that you operate, less allowable deductions for that trade or business. Net earnings also include your share of profit or loss in any partnership to which you belong. These are the same net earnings that we would count under the social security retirement insurance program and that you would report on your Federal income tax return. (See § 404.1080 of this chapter.)

(c) *Refunds of Federal income taxes and advance payments by employers made in accordance with the earned income credit provisions of the Internal Revenue Code.* Refunds on account of earned income credits are payments made to you under the provisions of section 43 of the Internal Revenue Code of 1954, as amended. These *refunds* may be greater than taxes you have paid. You may receive earned income tax credit payments along with any other Federal income tax refund you receive because of overpayment of your income tax, (Federal income tax refunds made on the basis of taxes you have already paid are not income to you as stated in § 416.1103(d).) Advance payments of earned income tax credits are made by your employer under the provisions of section 3507 of the same code. You can receive earned income tax credit payments only if you meet certain requirements of family composition and income limits.

(d) *Payments for services performed in a sheltered workshop or work activities center.* Payments for services performed in a sheltered workshop or work activities center are what you receive for participating in a program designed to help you become self-supporting.

(e) *Certain royalties and honoraria.* Royalties that are earned income are payments to an individual in connection with any publication of the work of the individual. (See § 416.1110(b) if you receive a royalty as part of your trade or business. See § 416.1121(c) if

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you receive another type of royalty.) Honoraria that are earned income are those portions of payments, such as an honorary payment, reward, or donation, received in consideration of services rendered for which no payment can be enforced by law. (See § 416.1120 if you receive another type of honorarium.)

[45 FR 65547, Oct. 3, 1980, as amended at 48 FR 23179, May 24, 1983; 50 FR 48574, Nov. 26, 1985; 56 FR 3212, Jan. 29, 1991; 59 FR 43471, Aug. 24, 1994]

§ 416.1111 How we count earned income.

(a) *Wages.* We count wages at the earliest of the following points: when you receive them or when they are credited to your account or set aside for your use. We determine wages for each month. We count wages for services performed as a member of a uniformed service (as defined in § 404.1330 of this chapter) as received in the month in which they are earned.

(b) *Net earnings from self-employment.* We count net earnings from self-employment on a taxable year basis. However, we divide the total of these earnings equally among the months in the taxable year to get your earnings for each month. For example, if your net earnings for a taxable year are $2,400, we consider that you received $200 in each month. If you have net losses from self-employment, we divide them over the taxable year in the same way, and we deduct them only from your other earned income.

(c) *Payments for services in a sheltered workshop or activities center.* We count payments you receive for services performed in a sheltered workshop or work activities center when you receive them or when they are set aside for your use. We determine the amount of the payments for each calendar quarter.

(d) *In-kind earned income.* We use the current market value of in-kind earned income for SSI purposes. (See § 416.1101 for a definition of current market value.) If you receive an item that is not fully paid for and are responsible for the unpaid balance, only the paid-up value is income to you. (See the example in § 416.1123(c)).

(e) *Royalties and honoraria.* We count payments of royalties to you in connection with any publication of your work, and honoraria, to the extent received for services rendered, at the earliest of the following points: when you receive them, when they are credited to your account, or when they are set aside for your use. (See § 416.1111(b) if you receive royalties as part of your trade or business.)

[45 FR 65547, Oct. 3, 1980, as amended at 48 FR 23179, May 24, 1983; 48 FR 30357, July 1, 1983; 50 FR 48574, Nov. 26, 1985; 58 FR 63889, Dec. 3, 1993; 59 FR 43471, Aug. 24, 1994; 71 FR 45378, Aug. 9, 2006]

§ 416.1112 Earned income we do not count.

(a) *General.* While we must know the source and amount of all of your earned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your income in the month. We never reduce your earned income below zero or apply any unused earned income exclusion to unearned income.

(b) *Other Federal laws.* Some Federal laws other than the Social Security Act provide that we cannot count some of your earned income for SSI purposes. We list the laws and exclusions in the appendix to this subpart which we update periodically.

(c) *Other earned income we do not count.* We do not count as earned income—

(1) Any refund of Federal income taxes you receive under section 32 of the Internal Revenue Code (relating to earned income tax credit) and any payment you receive from an employer under section 3507 of the Internal Revenue Code (relating to advance payment of earned income tax credit);

(2) The first $30 of earned income received in a calendar quarter if you receive it infrequently or irregularly. We consider income to be received infrequently if you receive it only once during a calendar quarter from a single source and you did not receive it in the month immediately preceding that month or in the month immediately subsequent to that month. We consider

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388-835-0345 << 388-835-0350 >> 388-835-0355

WAC 388-835-0350

No agency filings affecting this section since 2003

Can a resident trust account be charged for Title XIX services?

Resident trust accounts cannot be charged for services provided under Title XIX.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0350, filed 4/20/01, effective 5/21/01.]

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this section who receive only a State supplement if the State supplement meets the conditions specified in paragraph (c) of this section.

(b) The agency may provide Medicaid to all individuals receiving only State supplements if, except for their income, the individuals meet the more restrictive eligibility requirements under § 435.121 or SSI criteria, or to one or more of the following classifications of individuals who meet these criteria:

(1) All aged individuals.

(2) All blind individuals.

(3) All disabled individuals.

(4) Only aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(5) Only blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(6) Only disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(7) Individuals receiving a Federally-administered optional State supplement that meets the conditions specified in this section.

(8) Individuals in additional classifications specified by the Secretary.

(9) Reasonable groups of individuals, as specified by the State, receiving State-administered supplementary payments.

(c) Payments under the optional supplement program must be:

(1) Based on need and paid in cash on a regular basis;

(2) Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplements. Countable income is income remaining after deductions are applied. The income deductions may be more restrictive than required under SSI (see § 435.1006 for limitations on FFP in Medicaid expenditures for individuals receiving optional State supplements); and

(3) Available to all individuals in each classification in paragraph (b) of this section and available on a statewide basis. However, the plan may provide for variations in the income standard by political subdivision according to cost-of-living differences.

[58 FR 4928, Jan. 19, 1993]

§ 435.236 Individuals in institutions who are eligible under a special income level.

(a) If the agency provides Medicaid under § 435.211 to individuals in institutions who would be eligible for AFDC, SSI, or State supplements except for their institutional status, it may also cover aged, blind, and disabled individuals in institutions who—

(1) Because of their income, would not be eligible for SSI or State supplements if they were not institutionalized; but

(2) Have income below a level specified in the plan under § 435.722. (See § 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section.)

(b) The agency may cover individuals under this section whether or not the State pays optional supplements.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980. Redesignated at 58 FR 4928, Jan. 19, 1993]

Subpart D—Optional Coverage of the Medically Needy

§ 435.300 Scope.

This subpart specifies the option for coverage of medically needy individuals.

§ 435.301 General rules.

(a) An agency may provide Medicaid to individuals specified in this subpart who:

(1) Either:

(i) Have income that meets the applicable standards in §§ 435.811 and 435.814; or

(ii) If their income is more than allowed under the standard, have incurred medical expenses at least equal to the difference between their income and the applicable income standard; and

(2) Have resources that meet the applicable standards in §§ 435.840 and 435.843.

(b) If the agency chooses this option, the following provisions apply:

(1) The agency must provide Medicaid to the following individuals who meet the requirements of paragraph (a) of this section:

(i) All pregnant
course of their pre
for income and resc
gible for Medicaid
tional categorically
parts B or C of this

(ii) All individua
age who, except f
sources, would be e
as mandatory c
under subpart B of

(iii) All newborn
after October 1, 198
eligible as medical
ceiving Medicaid
child's birth. The
have applied and be
Medicaid on the d
mains eligible as
one year so long as
eligible and the ch
the woman's housel
basis of eligibility
cally needy, the chi
egorically needy
woman is considere
if she meets the
ments in any conse
following the birth

(iv) Women who,
plied for, were eligi
Medicaid services
on the day that th
The agency must
needy eligibility to
extended period fo
of pregnancy. This
the last day of the
the end of the mon
period, beginning
pregnancy, ends.
provided, regardles
woman's financial
may occur within t
These women are
tended period for a
plan that are pregr
fined in § 440.210(
chapter).

(2) The agency m
to any of the follo
viduals;

(i) Individuals un

(ii) Specified rela

(iii) Aged (§ 435.33

(iv) Blind (§§ 4
435.340).

(v) Disabled (§§
435.340).

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(i) All pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as mandatory or optional categorically needy under subparts B or C of this part;

(ii) All individuals under 18 years of age who, except for income and resources, would be eligible for Medicaid as mandatory categorically needy under subpart B of this part;

(iii) All newborn children born on or after October 1, 1984, to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as medically needy for one year so long as the woman remains eligible and the child is a member of the woman's household. If the woman's basis of eligibility changes to categorically needy, the child is eligible as categorically needy under § 435.117. The woman is considered to remain eligible if she meets the spend-down requirements in any consecutive budget period following the birth of the child.

(iv) Women who, while pregnant, applied for, were eligible for, and received Medicaid services as medically needy on the day that their pregnancy ends. The agency must provide medically needy eligibility to these women for an extended period following termination of pregnancy. This period extends from the last day of the pregnancy through the end of the month in which a 60-day period, beginning on the last day of pregnancy, ends. Eligibility must be provided, regardless of changes in the woman's financial circumstances that may occur within this extended period. These women are eligible for the extended period for all services under the plan that are pregnancy-related (as defined in § 440.210(c)(1) of this subchapter).

(2) The agency may provide Medicaid to any of the following groups of individuals;

(i) Individuals under age 21 (§ 435.308).

(ii) Specified relatives (§ 435.310).

(iii) Aged (§ 435.330.320 and 435.330).

(iv) Blind (§§ 435.322, 435.330 and 435.340).

(v) Disabled (§§ 435.324, 435.330, and 435.340).

(3) If the agency provides Medicaid to any individual in a group specified in paragraph (b)(2) of this section, the agency must provide Medicaid to all individuals eligible to be members of that group.

[46 FR 47986, Sept. 30, 1981, as amended at 52 FR 43072, Nov. 9, 1987; 52 FR 48438, Dec. 22, 1987; 55 FR 48609, Nov. 21, 1990; 58 FR 4929, Jan. 19, 1993]

§ 435.308 Medically needy coverage of individuals under age 21.

(a) If the agency provides Medicaid to the medically needy, it may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in paragraph (b) of this section:

(1) Who would not be covered under the mandatory medically needy group of individuals under 18 under § 435.301(b)(1)(ii); and

(2) Who meet the income and resource requirements of subpart I of this part.

(b) The agency may cover all individuals described in paragraph (a) of this section or reasonable classifications of those individuals. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or in part by a public agency.

(3) Individuals in nursing facilities when nursing facility services are provided under the plan to individuals within the age group selected under this provision. When the agency covers such individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

[46 FR 47986, Sept. 30, 1981, as amended at 58 FR 4929, Jan. 19, 1993]

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amount of income allowed for purposes of FFP under § 435.1007.

(f) The income standard may vary based on the variations between shelter costs in urban areas and rural areas.

[58 FR 4932, Jan. 19, 1993]

§ 435.814 Medically needy income standard: State plan requirements.

The State plan must specify the income standard for the covered medically needy groups.

[58 FR 4933, Jan. 19, 1993]

MEDICALLY NEEDY INCOME ELIGIBILITY

§ 435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section.

(a) *Budget periods.* (1) The agency must use budget periods of not more than 6 months to compute income. The agency may use more than one budget period.

(2) The agency may include in the budget period in which income is computed all or part of the 3-month retroactive period specified in § 435.914. The budget period can begin no earlier than the first month in the retroactive period in which the individual received covered services. This provision applies to all medically needy individuals except in groups for whom criteria more restrictive than that used in the SSI program apply.

(3) If the agency elects to begin the first budget period for the medically needy in any month of the 3-month period prior to the date of the application in which the applicant received covered services, this election applies to all medically needy groups.

(b) *Determining countable income.* The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind, or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those used in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in determining eligibility, under § 435.121, of the categorically needy.

(c) *Eligibility based on countable income.* If countable income determined under paragraph (b) of this section is equal to or less than the applicable income standard under § 435.814, the individual or family is eligible for Medicaid.

(d) *Deduction of incurred medical expenses.* If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f), and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) *Determination of deductible incurred expenses: Required deductions based on kinds of services.* Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under § 447.51 or § 447.53 of this subchapter;

(2) Expenses incurred by tl vidual or family or financially sible relatives for necessary and remedial services that ar nized under State law but not i in the plan;

(3) Expenses incurred by tl vidual or family or by financi sponsible relatives for necessa ical and remedial services tha cluded in the plan, including th exceed agency limitations on duration, or scope of services.

(f) *Determination of deductible expenses: Required deductions the age of bills.* Subject to th sions of paragraph (g), in dete incurred medical expenses tc ducted from income, the agen include the following:

(1) For the first budget perio ods that include only month the month of application for assistance, expenses incurre such period or periods, whethe unpaid, to the extent that the have not been deducted previ establishing eligibility;

(2) For the first prospectiv period that also includes any months before the month of tion for medical assistance, incurred during such budge whether paid or unpaid, to th that the expenses have not ducted previously in establish bility;

(3) For the first prospectiv period that includes none months preceding the month cation, expenses incurred du budget period and any of tl ceding months, whether paid c to the extent that the expe not been deducted previously lishing eligibility;

(4) For any of the 3 months the month of application tha includable under paragraph this section, expenses incurre month period that were a c ability of the individual in month for which a spenddow tion is made and that had not viously deducted from income lishing eligibility for medic ance;

(5) Current payments (tha ments made in the current t

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(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration, or scope of services.

(f) *Determination of deductible incurred expenses: Required deductions based on the age of bills.* Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) For the first budget period or periods that include only months before the month of application for medical assistance, expenses incurred during such period or periods, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(2) For the first prospective budget period that also includes any of the 3 months before the month of application for medical assistance, expenses incurred during such budget period, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(3) For the first prospective budget period that includes none of the months preceding the month of application, expenses incurred during such budget period and any of the 3 preceding months, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(4) For any of the 3 months preceding the month of application that are not includable under paragraph (f)(2) of this section, expenses incurred in the 3-month period that were a current liability of the individual in any such month for which a spenddown calculation is made and that had not been previously deducted from income in establishing eligibility for medical assistance;

(5) Current payments (that is, payments made in the current budget period) on other expenses incurred before the current budget period and not previously deducted from income in any budget period in establishing eligibility for such period; and

(6) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period but not previously deducted from income in establishing eligibility, to the extent that such expenses are unpaid and are:

(i) Described in paragraphs (e)(1) through (e)(3) of this section; and

(ii) Carried over from the preceding budget period or periods because the individual had a spenddown liability in each such preceding period that was met without deducting all such incurred, unpaid expenses.

(g) *Determination of deductible incurred medical expenses: Optional deductions.* In determining incurred medical expenses to be deducted from income, the agency—

(1) May include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate;

(2) May, to the extent determined by the State and specified in its approved plan, include expenses incurred earlier than the third month before the month of application (except States using more restrictive eligibility criteria under the option in section 1902(f) of the Act must deduct incurred expenses regardless of when the expenses were incurred); and

(3) May set reasonable limits on the amount to be deducted for expenses specified in paragraphs (e)(1), (e)(2), and (g)(2) of this section.

(h) *Order of deduction.* The agency must deduct incurred medical expenses that are deductible under paragraphs (e), (f), and (g) of this section in the order prescribed under one of the following three options:

(1) *Type of service.* Under this option, the agency deducts expenses in the following order based on type of expense or service:

(i) Cost-sharing expenses as specified in paragraph (e)(1) of this section.

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(ii) Services not included in the State plan as specified in paragraph (e)(2) of this section.

(iii) Services included in the State plan as specified in paragraph (e)(3) of this section but that exceed limitations on amounts, duration, or scope of services.

(iv) Services included in the State plan as specified in paragraph (e)(3) of this section but that are within agency limitations on amount, duration, or scope of services.

(2) *Chronological order by service date.* Under this option, the agency deducts expenses in chronological order by the date each service is furnished, or in the case of insurance premiums, coinsurance or deductible charges, the date such amounts are due. Expenses for services furnished on the same day may be deducted in any reasonable order established by the State.

(3) *Chronological order by bill submission date.* Under this option, the agency deducts expenses in chronological order by the date each bill is submitted to the agency by the individual. If more than one bill is submitted at one time, the agency must deduct the bills from income in the order prescribed in either paragraph (h)(1) or (h)(2) of this section.

(i) *Eligibility based on incurred medical expenses.* (1) Whether a State elects partial or full month coverage, an individual who is expected to contribute a portion of his or her income toward the costs of institutional care or home and community-based services under §§ 435.725, 435.726, 435.733, 435.735 or 435.832 is eligible on the first day of the applicable budget (spenddown) period—

(i) If his or her spenddown liability is met after the first day of the budget period; and

(ii) If beginning eligibility after the first day of the budget period makes the individual's share of health care expenses under §§ 435.725, 435.726, 435.733, 435.735 or 435.832 greater than the individual's contributable income determined under these sections.

(2) At the end of the prospective period specified in paragraphs (f)(2) and (f)(3) of this section, and any subsequent prospective period or, if earlier, when any significant change occurs, the agency must reconcile the projected amounts with the actual amounts incurred, or with changes in circumstances, to determine if the adjusted deduction of incurred expenses reduces income to the income standard.

(3) Except as provided in paragraph (i)(1) of this section, in States that elect partial month coverage, an individual is eligible for Medicaid on the day that the deduction of incurred health care expenses (and of projected institutional expenses if the agency elects the option under paragraph (g)(1) of this section) reduces income to the income standard.

(4) Except as provided in paragraph (i)(1) of this section, in States that elect full month coverage, an individual is eligible on the first day of the month in which spenddown liability is met.

(5) Expenses used to meet spenddown liability are not reimbursable under Medicaid. To the extent necessary to prevent the transfer of an individual's spenddown liability to the Medicaid program, States must reduce the amount of provider charges that would otherwise be reimbursable under Medicaid.

[59 FR 1672, Jan. 12, 1994]

§ 435.832 Post-eligibility treatment of income of institutionalized individuals: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income, as determined

RESEARCH GUIDE

Federal Procedure:

17 Fed Proc L Ed, Health, Education, and Welfare § 42:422.

INTERPRETIVE NOTES AND DECISIONS

1. Validity of regulations
2. Injunctive relief

1. Validity of regulations

Medicaid recipients' challenge to federal regulation implementing 42 USCS § 1396o(a)(3), which requires copayments to be "nominal in amount," must fail, even though copayment for inpatient hospital services in Kansas is $325, where Congress has adopted, parenthetically in statute, definition of "nominal in amount" long codified in 42 CFR § 447.54(c), because court is bound by Secretary's interpretation, since it has been given force and effect of law by legislative reenactment and ratification. Kansas Hosp. Ass'n v Whiteman (1994, DC Kan) 851 F Supp 401, 44 Soc Sec Rep Serv 524.

2. Injunctive relief

State is temporarily restrained from implementing amendment to increase co-payment requirement of Medicaid beneficiaries from $25 to $325 per admission for inpatient hospital services, where hospitals and individuals showed that amendment may cause them irreparable harm, outweighing any potential damage caused state by delay, and that public interest favors enforcement of public policy as expressed in Medicaid statutes and regulations, because plaintiffs make viable claim that proposed increase runs afoul of 42 USCS § 1396o requirement that any cost sharing be "nominal." Kansas Hosp. Ass'n v Whiteman (1993, DC Kan) 835 F Supp 1548, 42 Soc Sec Rep Serv 708.

Preliminary injunction is denied hospitals and individuals challenging proposed amendment to state Medicaid plan, where state submitted evidence showing that proposed increase of co-payment to $325 was determined after applying 50 percent to average, or typical, amount agency pays for each day of inpatient hospital care for Medicaid recipients, because plaintiffs are not likely to prevail on their claim that proposed co-payment is not "nominal in amount" as required by 42 USCS § 1396o(a)(3), (b)(3), since amount is consistent with federal regulations permitting state to impose fixed co-payment amount for inpatient hospital care. Kansas Hosp. Ass'n v Whiteman (1993, DC Kan) 835 F Supp 1556, 42 Soc Sec Rep Serv 716, 4 ADD 321, affd without op sub nom Williams v Whiteman (1994, CA10 Kan) 36 F3d 1106, reported in full (1994, CA10 Kan) 1994 US App LEXIS 25798.

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against the property of an individual on account of medical assistance rendered to him under a State plan. (1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

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(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI [42 USCS §§ 1381 et seq.]) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614 [42 USCS § 1382c], or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan. (1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan.

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

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(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI [42 USCS §§ 1381 et seq.]) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614 [42 USCS § 1382c]; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B), when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(4) For purposes of this subsection, the term ''estate'', with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(c) Taking into account certain transfers of assets. (1)(A) In order to meet the requirements of this subsection for purposes of section 1902(a)(18) [42 USCS § 1396a(a)(18)], the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is

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ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d), 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1915 [42 USCS § 1396n(c) or (d)].

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1905(a) [42 USCS § 1396d(a)(7), (22), or (24)], and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D) The date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

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(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under title XVI [42 USCS §§ 1381 et seq.]) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614 [42 USCS § 1382c];

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in

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subsection (d)(4)) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1614(a)(3)) [42 USCS § 1382c(a)(3)];

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary; [.]

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1902(f) [42 USCS § 1396a(f)]) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1613 [42 USCS § 1382b], without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts. (1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title [42 USCS §§ 1396 et seq.], subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal

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authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust—

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c).

(B) In the case of an irrevocable trust—

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c), and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1614(a)(3) [42 USCS § 1382c(a)(3)]) and

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which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title [42 USCS §§ 1396 et seq.].

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title [42 USCS §§ 1396 et seq.], and

(iii) the State makes medical assistance available to individuals described in section 1902(a)(10)(A)(ii)(V) [42 USCS § 1396a(a)(10)(A)-(ii)(V)], but does not make such assistance available to individuals for nursing facility services under section 1902(a)(10)(C) [42 USCS § 1396a(a)(10)(C)].

(C) A trust containing the assets of an individual who is disabled (as defined in section 1614(a)(3)) [42 USCS § 1382c(a)(3)] that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1614(a)(3)) [42 USCS § 1382c(a)(3)] by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this title [42 USCS §§ 1396 et seq.].

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term ''trust'' includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) Definitions. In this section, the following definitions shall apply:

(1) The term ''assets'', with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any

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income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1612 [42 USCS § 1382a].

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1902(a)(10)(A)(ii)(VI) [42 USCS § 1396a(a)(10)(A)(ii)(VI)].

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term "resources" has the meaning given such term in section 1613 [42 USCS § 1382b], without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

(Aug. 14, 1935, ch 531, Title XIX, § 1917, as added Sept. 3, 1982, P. L. 97-248, Title I, Subtitle B, § 132(b), 96 Stat. 370; Jan. 12, 1983, P. L. 97-448, Title III, § 309(b)(21), (22), 96 Stat. 2410; Dec. 22, 1987, P. L. 100-203, Title IV, Subtitle C, Part 2, § 4211(h)(12), 101 Stat. 1330-208; July 1, 1988, P. L. 100-360, Title III, § 303(b), Title IV, Subtitle B, § 411(l)(3)(1), 102 Stat. 760, 803; Oct. 13, 1988, P. L. 100-485, Title VI, § 608(d)(16)(B), 102 Stat. 2417; Dec. 19, 1989, P. L. 101-239, Title VI, Subtitle B, Part 2, § 6411(e)(1), 103 Stat. 2271; Aug. 10, 1993, P. L. 103-66, Title XIII, Ch 2, Subch B, Part II, §§ 13611(a)–(c), 13612(a)–(c), 107 Stat. 622, 627.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

Explanatory notes:

The bracketed period has been added at the end of subsec. (c)(2)(D) to indicate the probable intent of Congress to include such punctuation.

Effective date of section:

Act Sept. 3, 1982, P. L. 97-248, Title I, Subtitle B, § 132(d), 96 Stat. 373, which appears as a note to this section, provided in part that this section "shall become effective on the date of the enactment of this Act [enacted Sept. 3, 1982].".

Amendments:

1983. Act Jan. 12, 1982 (effective as if originally included as a part of this section as added by Act Sept. 3, 1982, as provided by § 309(c)(2) of the 1983 Act, which appears as 42 USCS § 426-1 note), in subsec. (b)(2)(B), in the concluding matter, substituted "who has lawfully resided" for "and has lawfully resided"; and in subsec. (c)(2)(B)(iii), in subcl. (I), substituted

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is made available under part B of title IV to children in foster care'', and added cl. (vi), and in subpara. (B), in cl. (i), substituted ''child welfare services are made available under part B of title IV on the basis of being a child in foster care or'' for ''aid or assistance is made available under part B of title IV to children in foster care'', and added cl. (ix); in subsec. (c), in para. (1), in the introductory matter, substituted ''most (or more) cost effective'' for ''least (or less) costly effective'', and in subpara. (B), substituted ''be imposed under subsection (a) due to the application of'' for ''otherwise be imposed under'', and, in para. (2), in subpara. (B), substituted ''not subject to cost sharing under subsection (a) due to the application of paragraph (1)(B)'' for ''otherwise not subject to cost sharing due to the application of subsection (b)(3)(B)'', and in subpara. (C), inserted ''under subsection (a)(2)(B) or''; and, in subsec. (e), in para. (2), in subpara. (A), substituted the heading for one which read: ''For poorest beneficiaries.'', and, in the text, inserted ''who is not described in subparagraph (B)'', and substituted ''under subsection (b)(1)(B)(ii)'' for ''under subsection (b)(1)'', in subpara. (B), substituted ''described in subsection (a)(2)(A) or who is not subject to cost sharing under subsection (b)(3)(B) with respect to non-emergency services described in paragraph (1)'' for ''who is otherwise not subject to cost sharing under subsection (b)(3)'', and in subpara. (C), inserted ''under subsection (a)(2)(B) or'' and ''or section 1916'', and in para. (4)(A), deleted ''the physician determines'' preceding ''do not constitute''.

Other provisions:

Applicability of section. This section applies to cost sharing imposed for items and services furnished on or after March 31, 2006, pursuant to § 6041(c) of Act Feb. 8, 2006, P. L. 109-171, which appears as 42 USCS § 1396o note.

Applicability of amendment made by § 6042(a) of Act Feb. 8, 2006. Act Feb. 8, 2006, P. L. 109-171, Title VI, Subtitle A, Ch. 4, § 6042(b), 120 Stat. 86, provides: ''The amendment made by subsection (a) [inserting subsec. (c) of this section] shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.''

Effective date of Dec. 20, 2006 amendments. Act Dec. 20, 2006, P. L. 109-432, Div B, Title IV, § 405(a)(6), 120 Stat. 2998, provides: ''The amendments made by this subsection shall take effect as if included in the amendments made by sections 6041(a) of the Deficit Reduction Act of 2005 [Act Feb. 8, 2006, P. L. 109-171], except that insofar as such amendments are to, or relate to, subsection (c) or (e) of section 1916A of the Social Security Act, such amendments shall take effect as if included in the amendments made by section 6042 or 6043, respectively, of the Deficit Reduction Act of 2005 [Act Feb. 8, 2006, P. L. 109-171].''.

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) [Unchanged]

(b) Adjustment or recovery of medical assistance correctly paid under a State plan. (1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A), (B) [Unchanged]

(C)(i) [Unchanged]

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I), (II) [Unchanged]

(iii) For purposes of this paragraph, the term ''qualified State long-term care insurance partnership'' means an approved State plan amendment under this title [42 USCS §§ 1396 et seq.] that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986 [26 USCS § 7702B(b)]) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

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(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1902(a)(5) [42 USCS § 1396a(a)(5)] provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2)–(4) [Unchanged]

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

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(XIII) Section 22 (relating to filing requirements for marketing).
(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
(XV) Section 24 (relating to suitability).
(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).
(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).
(XVIII) Section 29 (relating to standard format outline of coverage).
(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:
(I) Section 6C (relating to preexisting conditions).
(II) Section 6D (relating to prior hospitalization).
(III) The provisions of section 8 relating to contingent nonforfeiture benefits.
(IV) Section 6F (relating to right to return).
(V) Section 6G (relating to outline of coverage).
(VI) Section 6H (relating to requirements for certificates under group plans).
(VII) Section 6J (relating to policy summary).
(VIII) Section 6K (relating to monthly reports on accelerated death benefits).
(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)—
(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);
(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and
(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets. (1)(A) [Unchanged]

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005 [enacted Feb. 8, 2006], 60 months) before the date specified in clause (ii).

(ii) [Unchanged]

(C) [Unchanged]

(D)(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005 [enacted Feb. 8, 2006], the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005 [enacted Feb. 8, 2006], the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but

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for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i)–(iii) [Unchanged]

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this title [42 USCS §§ 1396 et seq.]; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title [42 USCS §§ 1396 et seq.] unless—

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986 [26 USCS § 408]; or

(II) purchased with proceeds from—

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code [26 USCS § 408];

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code [26 USCS § 408(k)]); or

(cc) a Roth IRA described in section 408A of such Code [26 USCS § 408A]; or

(ii) the annuity—

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A)–(C) [Unchanged]

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3)–(5) [Unchanged]

(d) [Unchanged]

(e)(1) In order to meet the requirements of this section for purposes of section 1902(a)(18) [42 USCS § 1396a(a)(18)], a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f)(1)(A) Notwithstanding any other provision of this title [42 USCS §§ 1396 et seq.], subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1902(a)(1) [42 USCS § 1396a(a)(1)] (relating to statewideness) and section 1902(a)(10)(B) [42 USCS § 1396a(a)(10)(B)] (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI [42 USCS §§ 1381 et seq.]) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614 [42 USCS § 1382c],

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

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(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(j) **Treatment of entrance fees of individuals residing in continuing care retirement communities.** (1) In general. For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title [42 USCS §§ 1396 et seq.], the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee. For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) **Definitions.** In this section, the following definitions shall apply:

(1) The term ''assets'', with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term ''income'' has the meaning given such term in section 1612 [42 USCS § 1382a].

(3) The term ''institutionalized individual'' means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1902(a)(10)(A)(ii)(VI) [42 USCS § 1396a(a)(10)(A)(ii)(VI)].

(4) The term ''noninstitutionalized individual'' means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term ''resources'' has the meaning given such term in section 1613 [42 USCS § 1382b], without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

(As amended Feb. 8, 2006, P. L. 109-171, Title VI, Subtitle A, Ch. 2, Subch. A, §§ 6011(a), (b), (e), 6012(a)–(c), 6014(a), 6015(b), 6016(a)–(d), Subch. B, § 6021(a)(1), 120 Stat. 61, 62, 64, 65, 68; Dec. 20, 2006, P. L. 109-432, Div B, Title IV, § 405(b)(1), 120 Stat. 2998.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

Amendments:

2006. Act Feb. 8, 2006, in subsec. (b), in para. (1)(C), in cl. (ii), inserted ''and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))'', and added cl. (iii)–(vi), and added para. (5)

Such Act further (applicable to transfers made on or after enactment, as provided by § 6011(c) of such Act, which appears as a note to this section), in subsec. (c), in para. (1), in subpara. (B)(i), inserted ''or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005'', and, in subpara. (D), substituted ''(D)(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date'' for ''(D) The date'', and added cl. (ii), and, in para. (2), in subpara. (D), substituted the concluding period for a semicolon, and added the concluding matter.

Such Act further (applicable to transactions occurring on or after enactment, as provided by § 6012(d) of such Act, which appears as a note to this section), in subsec. (c)(1), added subparas. (F) and (G); redesignated subsec. (e) as subsec. (f); and inserted new subsec. (e).

Such Act further (applicable as provided by § 6014(b) of such Act, which appears as a note to this section), redesignated subsec. (f) as subsec. (g); and inserted new subsec. (f).

Such Act further redesignated subsec. (g) as subsec. (h); and inserted new subsec. (g).

Such Act further (applicable as provided by § 6016(e) of such Act, which appears as a note to this section), in subsec. (c)(1), in subpara. (E), added cl. (iv), and added subparas. (H)–(J).

Act Dec. 20, 2006 (effective as if included in Act Feb. 8, 2006, as provided by § 405(b)(2) of Div B of Act Dec. 20, 2006, which appears as a note to this section), in subsec. (c)(1)(F)(i), substituted ''institutionalized individual'' for ''annuitant''.

§ 433.32 Fiscal policies and accountability.

A State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will—

(a) Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements;

(b) Retain records for 3 years from date of submission of a final expenditure report;

(c) Retain records beyond the 3-year period if audit findings have not been resolved; and

(d) Retain records for nonexpendable property acquired under a Federal grant for 3 years from the date of final disposition of that property.

[44 FR 17935, Mar. 23, 1979]

§ 433.34 Cost allocation.

A State plan under Title XIX of the Social Security Act must provide that the single or appropriate Agency will have an approved cost allocation plan on file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95. Subpart E also sets forth the effect on FFP if the requirements contained in that subpart are not met.

[47 FR 17490, Apr. 23, 1982]

§ 433.35 Equipment—Federal financial participation.

Claims for Federal financial participation in the cost of equipment under the Medicaid Program are determined in accordance with subpart G of 45 CFR part 95. Requirements concerning the management and disposition of equipment under the Medicaid Program are also prescribed in subpart G of 45 CFR part 95.

[47 FR 41564, Sept. 21, 1982]

§ 433.36 Liens and recoveries.

(a) *Basis and purpose.* This section implements sections 1902(a)(18) and 1917(a) and (b) of the Act, which describe the conditions under which an agency may impose a lien against a recipient's property, and when an agency may make an adjustment or recover funds in satisfaction of the claim against the individual's estate or real property.

(b) *Definition of property.* For purposes of this section, "property" includes the homestead and all other personal and real property in which the recipient has a legal interest.

(c) *State plan requirement.* If a State chooses to impose a lien against an individual's real property (or as provided in paragraph (g)(1) of this section, personal property), the State plan must provide that the provisions of paragraphs (d) through (i) of this section are met.

(d) *Procedures.* The State plan must specify the process by which the State will determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home as provided in paragraph (g)(2)(ii) of this section. The description of the process must include the type of notice to be given the individual, the process by which the individual will be given the opportunity for a hearing, the hearing procedures, and by whom and on what basis the determination that the individual cannot reasonably be expected to be discharged from the institution will be made. The notice to the individual must explain what is meant by the term lien, and that imposing a lien does not mean that the individual will lose ownership of the home.

(e) *Definitions.* The State plan must define the following terms used in this section:

(1) Individual's home.

(2) Equity interest in home.

(3) Residing in the home for at least 1 (or 2) year(s).

(4) On a continuing basis.

(5) Discharge from the medical institution and return home.

(6) Lawfully residing.

(f) *Exception.* The State plan must specify the criteria by which a son or daughter can establish to the agency's satisfaction that he or she has been providing care which permitted the individual to reside at home rather than in an institution, as provided in paragraph (h)(2)(iii)(B) of this section.

(g) *Lien provisions*—(1) *Incorrect payments.* The agency may place a lien against an individual's property, both

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personal and real, before his or her death because of Medicaid claims paid or to be paid on behalf of that individual following a court judgement which determined that benefits were incorrectly paid for that individual.

(2) *Correct payments.* Except as provided in paragraph (g)(3) of this section, the agency may place a lien against the real property of an individual at any age before his or her death because of Medicaid claims paid or to be paid for that individual when—

(i) An individual is an inpatient of a medical institution and must, as a condition of receiving services in the institution under the State plan, apply his or her income to the cost of care as provided in §§ 435.725, 435.832 and 436.832; and

(ii) The agency determines that he or she cannot reasonably be expected to be discharged and return home. The agency must notify the individual of its intention to make that determination and provide an opportunity for a hearing in accordance with State established procedures before the determination is made. The notice to an individual must include an explanation of liens and the effect on an individual's ownership of property.

(3) *Restrictions on placing liens.* The agency may not place a lien on an individual's home under paragraph (g)(2) of this section if any of the following individuals is lawfully residing in the home:

(i) The spouse;

(ii) The individual's child who is under age 21 or blind or disabled as defined in the State plan; or

(iii) The individual's sibling (who has an equity interest in the home, and who was residing in the individual's home for at least one year immediately before the date the individual was admitted to the medical institution).

(4) *Termination of lien.* Any lien imposed on an individual's real property under paragraph (g)(2) of this section will dissolve when that individual is discharged from the medical institution and returns home.

(h) *Adjustments and recoveries.* (1) The agency may make an adjustment or recover funds for Medicaid claims correctly paid for an individual as follows:

(i) From the estate of any individual who was 65 years of age or older when he or she received Medicaid; and

(ii) From the estate or upon sale of the property subject to a lien when the individual is institutionalized as described in paragraph (g)(2) of this section.

(2) The agency may make an adjustment or recovery under paragraph (h)(1) of this section only:

(i) After the death of the individual's surviving spouse; and

(ii) When the individual has no surviving child under age 21 or blind or disabled as defined in the State plan; and

(iii) In the case of liens placed on an individual's home under paragraph (g)(2) of this section, when there is no—

(A) Sibling of the individual residing in the home, who has resided there for at least one year immediately before the date of the individual's admission to the institution, and has resided there on a continuous basis since that time; or

(B) Son or daughter of the individual residing in the home, who has resided there for at least two years immediately before the date of the individual's admission to the institution, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he or she has been providing care which permitted the individual to reside at home rather than in an institution.

(i) *Prohibition of reduction of money payments.* No money payment under another program may be reduced as a means of recovering Medicaid claims incorrectly paid.

[43 FR 45201, Sept. 29, 1978, as amended at 47 FR 43647, Oct. 1, 1982; 47 FR 49847, Nov. 3, 1982]

§ 433.37 Reporting provider payments to Internal Revenue Service.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes requirements concerning—

(1) Identification of providers; and

(2) Compliance with the information reporting requirements of the Internal Revenue Code.

(b) *Identification of providers.* A State plan must provide for the identification of providers by—

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(c) The agency must apply the income standards established under this section effective with the first day of a period of not less than 30 consecutive days of institutionalization.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 53 FR 3595, Feb. 8, 1988. Redesignated and amended at 58 FR 4932, Jan. 19, 1993]

§ 435.631 General requirements for determining income eligibility in States using more restrictive requirements for Medicaid than SSI.

(a) *Income eligibility methods.* In determining income eligibility of aged, blind, and disabled individuals in a State using more restrictive eligibility requirements than SSI, the agency must use the methods for treating income elected under §§ 435.121 and 435.230, under § 435.601. The methods used must be comparable for all individuals within each category of individuals under § 435.121 and each category of individuals within each optional categorically needy group included under § 435.230 and for each category of individuals under the medically needy option described under § 435.800.

(b) *Categorically needy versus medically needy eligibility.* (1) Individuals who have income equal to, or below, the categorically needy income standards described in §§ 435.121 and 435.230 are categorically needy in States that include the medically needy under their plans.

(2) Categorically needy eligibility in States that do not include the medically needy is determined in accordance with the provisions of § 435.121 (e)(4) and (e)(5).

[58 FR 4932, Jan. 19, 1993]

§ 435.640 Protected Medicaid eligibility for individuals eligible in December 1973.

In determining whether individuals continue to meet the income requirements used in December 1973, for purposes of determining eligibility under §§ 435.131, 435.132, and 435.133, the agency must deduct increased OASDI payments to the same extent that these deductions were in effect in December 1973. These deductions are required by section 306 of the Social Security Amendments of 1972 (Pub. L. 92–603) and section 1007 of Pub. L. 91–172 (enacted Dec. 30, 1969), modified by section 304 of Pub. L. 92–603.

[43 FR 45204, Sept. 29, 1978. Redesignated at 58 FR 4932, Jan. 19, 1993]

Subpart H—Specific Post-Eligibility Financial Requirements for the Categorically Needy

§ 435.700 Scope.

This subpart prescribes specific financial requirements for determining the post-eligibility treatment of income of categorically needy individuals, including requirements for applying patient income to the cost of care.

[58 FR 4931, Jan. 19, 1993]

§ 435.725 Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income,

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities.

(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under § 435.110 or § 435.120.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

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(c) *Required deductions.* In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under § 435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under § 435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) *Continued SSI and SSP benefits.* The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an

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individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 48 FR 5735, Feb. 8, 1983; 53 FR 3595, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

§ 435.726 Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217 and are receiving home and community-based services furnished under a waiver of Medicaid requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically

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Fob JAMES, as Governor, and on behalf of the State of Alabama and its citizens; Alabama Medical Services Administration; and W. H. Kerns, Commissioner, Medical Assistance, Plaintiffs, v. Patricia Roberts HARRIS, Secretary of Health and Human Services; Leonard D. Schaeffer, Administrator, Health Care Financing Administration; Virginia M. Smyth, Regional Administrator, Region IV, Defendants

Civ. A. No. 80-170-N

UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF ALABAMA, NORTHERN DIVISION

499 F. Supp. 594; 1980 U.S. Dist. LEXIS 16013

September 26, 1980

CASE SUMMARY:

PROCEDURAL POSTURE: Plaintiffs, the Governor of Alabama and state health officials, filed an action against defendants, the Secretary of Health and Human Services and federal health officials, seeking a declaratory judgment that Alabama Act No. 80-113, which changed state funding regulations for the Medicaid program, did not contravene federal law. The parties filed cross-motions for summary judgment.

OVERVIEW: Alabama participated in the Medicaid program. Prior to the passage of Act. No. 80-113, Alabama followed the practice used by other states of deducting Medicaid patients' incomes from the cost of care of the nursing homes and thereafter seeking federal matching funds only on this reduced amount. However, after the passage of the Act, the patient's income was appropriated by the state and transformed into state funds, so that federal funds were sought on the entire amount. The court awarded summary judgment to defendants in plaintiffs' action seeking a declaratory judgment that the Act did not contravene federal law. The court held that even though the states were given wide latitude as to how they would raise state funds for the Medicaid program, it was clear that the plan of Congress did not include taking the patient's money and allowing it to be called state matching funds. Requiring the payment of the entire cost of care, as plaintiffs were doing pursuant to the Act, was a direct violation of 42 C.F.R. § 435.725, and thus a violation of a condition for obtaining federal matching funds.

OUTCOME: The court granted defendants' motion for summary judgment and denied the summary judgment motion filed by plaintiffs.

CORE TERMS: patient's, nursing homes, state funds, federal governments, social security, medical services, matching funds, allowance, matching, state agency, personal needs, eligible, monthly, appropriating, deducting, nursing, security income, federal funds, tax collector, medical assistance, non-protected, construing, rulemaking, reduction, skilled, judgment filed, arguments of counsel, federal statutes, strong evidence, statutory scheme

LexisNexis(R) Headnotes

Governments > State & Territorial Governments > General Overview
Public Health & Welfare Law > Healthcare > Services for Disabled & Elderly Persons > Care Facilities > Nursing Facilities
Public Health & Welfare Law > Social Security > Medicaid > State Plans > Approvals
[HN1] Title XIX of the Social Security Act of 1965, 42 U.S.C.S. § 1396 et seq., establishes a program, commonly termed Medicaid, to furnish medical assistance to certain needy individuals whose resources are insufficient to meet the cost of necessary medical services, including care in skilled nursing homes. States desiring to participate in this program, among other things, are required to establish a single state agency to administer this program, and to submit a state plan, setting out the proposed method of operation. The plan must be approved by the Secretary of the Department of Health and Human

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Services, formerly the Department of Health, Education and Welfare. Although states are not required to participate in this program, all states have chosen to do so.Medicaid is financed jointly by the federal and state governments through a procedure of federal matching of state funds. Prior to the beginning of each quarter, each state is required to submit a report to the Secretary estimating the expected expenditures for approved medical care. The report must also provide the amount appropriated or made available by the state for such expenditures, denominated as state funds.The actual administration of the program is delegated to the states. The state agency receives the federal funds and makes payments directly to the providers of medical assistance, including skilled nursing homes.

Governments > Legislation > Interpretation
[HN2] The court when construing the statute must look to the object in view, and never adopt an interpretation that will defeat its own purpose. The court must look less at the letter or words of the statute, than at the context, the subject matter, the consequences and effects, and the reason and spirit of the law, in endeavoring to arrive at the will of the law giver.

Family Law > Marital Termination & Spousal Support > Spousal Support > General Overview
Healthcare Law > Actions Against Facilities > Facility Liability > Nursing Facilities
Public Health & Welfare Law > Healthcare > Services for Disabled & Elderly Persons > Care Facilities > Nursing Facilities
[HN3] The statutory scheme of Congress and the federal regulations is to have contributions for Medicaid from three sources; the federal government, the state, and the patient. Even though the state is given wide latitude as to how it shall raise the "state funds," it seems clear that the plan does not include taking the patient's money and allowing it to be called state matching funds.Moreover, the method selected by Alabama of appropriating the income of the patients in the nursing homes clearly violates certain federal regulations, in particular, 42 C.F.R. § 435.725. This regulation provides in part as follows: The agency must reduce its payment to an institution for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) from the individual's income. The individual's specified in paragraph (b) are those eligible for Medicaid and are either aged, blind, disabled, or receive assistance under Supplemental Security Income or Aid to Families with Dependent Children. Commonly denominated as protected income, these amounts are allowances for personal needs, spouse and family maintenance, and expenses for medical and remedial care that are not subject to payment by a third party.

Healthcare Law > Actions Against Facilities > Facility Liability > Nursing Facilities
Public Health & Welfare Law > Healthcare > Services for Disabled & Elderly Persons > Care Facilities > General Overview
Public Health & Welfare Law > Social Security > Medicaid > General Overview
[HN4] The regulation 42 C.F.R. § 435.725 provides that the agency "must" reduce its payments to the nursing homes by a patient's non-protected income. This is not merely an eligibility standard that requires a patient's income to be applied to the cost of care. Rather, it is a post-eligibility command for the reduction of payment. The payment of the entire amount of cost of care, as Alabama has done since April 1, 1980, is a direct violation of § 435.725 and thus, a violation of a condition for obtaining federal matching funds.

COUNSEL: **[**1]** Charles A. Graddick, Atty. Gen., State of Ala., Ira DeMent (Sp. Counsel to Governor Fob James), Herman Hamilton, Jr. (Sp. Asst. Atty. Gen.) and Shapard D. Ashley, Montgomery, Ala., for plaintiffs.

Barry E. Teague, U. S. Atty., Kenneth E. Vines, Asst. U. S. Atty., Montgomery, Ala., and Carl H. Harper, Regional Atty., F. Richard Waitsman, Asst. Regional Atty., Dept. of Health, Ed. & Welfare, Atlanta, Ga., for defendants.

OPINION BY: HOBBS

OPINION

[*595] MEMORANDUM OPINION

This cause is before the Court on defendants' motion for summary judgment filed herein on July 22, 1980, and on plaintiffs' motion for summary judgment filed herein on August 1, 1980. Said motions were submitted to the Court and oral arguments of counsel were heard on September 2, 1980. Upon consideration of the motions, affidavits, briefs and arguments of counsel, this Court finds that when construing the evidence in favor of the plaintiffs there remains no genuine issue as to any material fact and that the defendants are entitled to a judgment as a matter of law for the reasons hereinafter stated.

Jurisdiction of this Court is founded on an actual controversy under 28 U.S.C. § 1331, within the context of **[**2]** 28 U.S.C. § 2201.

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[HN1] Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396 et seq., established a program, commonly termed "Medicaid," to furnish medical assistance to certain needy individuals whose resources are insufficient to meet the cost of necessary medical services, including care in skilled nursing homes. States desiring to participate in this program, among other things, are required to establish a single state agency to administer this program, and to submit a state plan, setting out the proposed method of operation. The plan must be approved by the Secretary of the Department of Health and Human Services, formerly the Department of Health, Education and Welfare (hereinafter referred to as Secretary). Although states are not required to participate in this program, all states have chosen to do so.

Medicaid is financed jointly by the federal and state governments through a procedure of federal matching of state funds. Prior to the beginning of each quarter, each state is required to submit a report to the Secretary estimating the expected expenditures for approved medical care. The report must also provide the amount appropriated or made available by the state **[**3]** for such expenditures, denominated as state funds.

The actual administration of the program is delegated to the states. The state agency receives the federal funds and makes payments directly to the providers of medical assistance, including skilled nursing homes.

Alabama has been participating in the Medicaid program with the Alabama Medical Services Administration serving as its single state agency. Prior to the passage of Act No. 80-113, 1980 Regular Session, Alabama followed the practice pursued by all other states of deducting Medicaid patients' income from the cost of care of the nursing homes, and thereafter seeking federal matching only on this reduced amount. (Although the parties refer to the federal and state funds as "matching" funds, actually **[*596]** in Alabama federal funds are contributed on a basis of approximately 70 per cent federal funds and 30 per cent state funds.)

For example, if the monthly charges of a nursing home were $ 600.00 and if a patient in a nursing home received $ 225.00 in social security monthly income, a minimum of $ 25.00 of this sum would be set aside as a personal needs allowance. The balance of $ 200.00 would be paid to the nursing **[**4]** home and the state and federal governments would contribute a total of $ 400.00 with the federal government absorbing approximately 70 per cent of this $ 400.00 expense, or $ 280.00, and the state, 30 per cent, or $ 120.00.

Act No. 80-113 and the Alabama regulations promulgated pursuant to said Act require the patients to sign a form authorizing the nursing home to receive all earned and unearned income of the patients except Supplemental Security Income payment, the personal needs allowance and sheltered workshop earnings. A patient who fails or refuses to abide by this rule will become ineligible for Medicaid benefits. Under the provisions of Act No. 80-113, the nursing home immediately pays this money to the county tax collector who, in turn pays the funds directly to the Alabama Medical Services Administration.

This income of the patient in the nursing home does not go to reduce the gross amount required to be paid by the state and federal governments. Under Act No. 80-113, the patient's income by reason of its collection by the state tax collector is transformed into state funds and its ultimate contribution to the cost of the patient's nursing home care is deemed to be part **[**5]** of the state's matching funds. The impact of Act No. 80-113 may be seen by returning to the example in one of the preceding paragraphs. Under Act No. 80-113, the patient's monthly social security income of $ 225.00 is reduced to $ 200.00 after deducting the personal needs allowance, which is then paid to the county tax collector. The state and federal governments must now pay their proportionate cost of the $ 600.00 monthly nursing home expense. The federal government pays 70 per cent or $ 420.00, and the state pays 30 per cent, or $ 180.00. Thus, by Act No. 80-113, in the hypothetical, Alabama has transformed an expense for its Alabama citizens residing in nursing homes of $ 120.00 per patient to a profit for the state of $ 20.00 per patient. Such an unnatural result from a plan which must have been approved by the federal agency charged with administering the program would seem highly unlikely. The fact that Alabama has not availed itself of this lucrative turnaround for the many years it has operated under the Medicaid program is also strong evidence that the parties heretofore have not construed the regulations as permitting the result sought to be achieved by Act No. 80-113. **[**6]** Obviously if the result sought by this Alabama Act is consistent with the terms prescribed by the Department of Health, Education and Welfare regulations, other states will adopt similar state laws. The absence of such state efforts by any state other than the belated action of Alabama in 1980 is also strong evidence that the parties operating under these federal regulations for many years have construed those regulations as not permitting what Alabama has attempted.

The Regional Administrator notified the Alabama Medical Services Administration that the procedure set out in Act No. 80-113 violated certain federal statutes and regulations and that income of the patients is not eligible to be considered as state funds for matching. Alabama Medical Services Administration and its Commissioner then filed this declaratory judgment action requesting this Court to find that Act No. 80-113 does not contravene federal statutes or regulations. In addition, plaintiffs requested a declaration that said Act may be implemented with the funds collected thereunder deemed eligible for federal matching.

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This case is one of first impression in that, as already noted, no other state has required [**7] nursing home patients to pay their income directly to the state with the claim that these funds provided by the patient qualified as state funds eligible for federal [*597] matching. The basis of Alabama's argument in support of the validity of this method is that no provision in the Social Security Act prohibits a state from appropriating patients' income and qualifying such funds as state funds. Hence, plaintiffs contend that they have merely chosen one of the many available methods for raising funds.

It is clear that the purpose of the Social Security Act and the regulations formulated thereunder is for the cost of nursing care to be shared by the patient, the state, and the federal government. The patient's share, if he has a source of income, is to be paid to the nursing home with the remainder of the nursing home cost to be shared by the state and federal governments. This purpose has been recognized and followed by every state, including Alabama, until Alabama enacted Act No. 80-113 in March, 1980.

Even if the Social Security Act did not expressly prohibit Alabama from treating the patient's income as a source for state matching funds, [HN2] the Court when construing the [**8] statute "must look to the object in view, and never adopt an interpretation that will defeat its own purpose." (The Emily) 9 Wheat. 381, 388, 22 U.S. 381, 388, 6 L. Ed. 116 (1824). This concept of statutory construction was long ago articulated by the Alabama Supreme Court as follows:

> The court (must) look less at the letter or words of the statute, than at the context, the subject matter, the consequences and effects, and the reason and spirit of the law, in endeavoring to arrive at the will of the law giver. Thompson v. State, 20 Ala. 54, 62 (1852).

As already stated, this Court is of the opinion that [HN3] the statutory scheme envisioned by Congress and the federal regulations was to have contributions from three sources; i.e., the federal government, the state, and the patient. Even though the state is given wide latitude as to how it shall raise the "state funds," it seems clear to the Court that the plan did not include taking the patient's money and allowing it to be called state matching funds.

Moreover, the method selected by Alabama of appropriating the income of the patients in the nursing homes clearly violates certain federal regulations, in particular, 42 CFR § [**9] 435.725. This regulation provides in pertinent part as follows:

> The agency must reduce its payment to an institution for services provided to an individual specified in paragraph (b) * of this section, by the amount that remains after deducting the amounts specified in paragraph (c) ** from the individual's income. ***

* The individual's specified in paragraph (b) are those eligible for Medicaid and are either aged, blind, disabled, or receive assistance under Supplemental Security Income or Aid to Families with Dependent Children.

** Commonly denominated as protected income, these amounts are allowances for personal needs, spouse and family maintenance, and expenses for medical and remedial care that are not subject to payment by a third party.

*** On April 11, 1980, subsequent to the enactment of Act No. 80-113, the phrase "the amount that remains after" was inserted in the above named regulation. 45 Fed.Reg. 24878, 24884 (April 11, 1980). Plaintiffs have argued that this regulation is inapplicable, contending that the insertion caused a completely different approach and therefore is a substantive change requiring compliance with the normal rulemaking process as set forth at 5 U.S.C. § 553. Plaintiffs admit that the regulation after the change requires a reduction to the nursing home by the amount of a patient's nonprotected income. They claim, however, that prior to the change, the state was only required to reduce its payment by the amount of the personal needs allowance. But prior to the change and the enactment of Act No. 80-113, Alabama did not follow this approach. Rather, Alabama deducted the full amount of the patient's income, hence indicating that Alabama considered this to be the proper interpretation of the regulation.

In addition, the Department classified the change as one correcting "technical and wording errors." 45 Fed.Reg. 24878 (April 11, 1980). It is a well settled principle of law that "the construction of a statute by those charged with its execution should be followed unless there are compelling indications that it is wrong. ..." New York Dept. of Social Services v. Dublino, 413 U.S. 405, 421, 93 S. Ct. 2507, 2516, 37 L. Ed. 2d 688 (1972). The Court recognizes that this precise point is not at issue, but concludes that an agency's interpretation of its own regulation is entitled to even greater deference.

Moreover, the Court is of the opinion that the only logical interpretation of the regulation prior to the change was that the state agency was required to reduce its payments to nursing facilities by the Medicaid recipients' non-protected incomes. While the regulation was perhaps ambiguous, the change served merely as a clarification or interpretation. Therefore, compliance with the rulemaking procedures of 5 U.S.C. § 553 was not required, 5 U.S.C. § 553(b) (A), and 42 CFR § 435.725 is applicable to the present case.

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[10]** [HN4] The regulation provides that the agency "must" reduce its payments to the **[*598]** nursing homes by a patient's non-protected income. This is not merely an eligibility standard, as plaintiffs argue, that requires a patient's income to be applied to the cost of care. Rather, it is a post-eligibility command for the reduction of payment. The payment of the entire amount of cost of care, as Alabama has done since April 1, 1980, is a direct violation of 42 CFR § 435.725 and thus, a violation of a condition for obtaining federal matching funds.

This Court appreciates the difficulty of Alabama and other states in trying to find the revenue to meet the soaring costs of funding the state's share of the Medicaid program. But the course pursued by Alabama of appropriating the patient's income, running that income through the tax collector and then designating those funds as state funds will not succeed. The program of joint state and federal funding of the Medicaid program is concerned with substance, not form. Act No. 80-113 violates not only express regulations but also the statutory scheme for financing the Medicaid program. A judgment and order will be entered in accordance **[**11]** with this memorandum opinion.

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1 of 1 DOCUMENT

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Petitioners v. HEIDI AHLBORN

No. 04-1506

SUPREME COURT OF THE UNITED STATES

547 U.S. 268; 126 S. Ct. 1752; 164 L. Ed. 2d 459; 2006 U.S. LEXIS 3455; 74 U.S.L.W. 4214; 19 Fla. L. Weekly Fed. S 169

February 27, 2006, Argued
May 1, 2006, Decided

NOTICE:

The LEXIS pagination of this document is subject to change pending release of the final published version.

PRIOR HISTORY: ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT.
Ahlborn v. Ark. Dep't of Human Servs., 397 F.3d 620, 2005 U.S. App. LEXIS 2015 (8th Cir. Ark., 2005)

DISPOSITION: Affirmed.

CASE SUMMARY:

PROCEDURAL POSTURE: Respondent recipient of Medicaid benefits sued petitioner Arkansas Department of Health and Human Services (ADHS), alleging that the ADHS asserted a lien against a tort settlement by the recipient for the full amount of Medicaid benefits in violation of federal Medicaid laws. Upon the grant of a writ of certiorari, the ADHS appealed the judgment of the United States Court of Appeals for the Eighth Circuit which held that the lien was unlawful.

OVERVIEW: The recipient was severely and permanently injured and received Medicaid benefits from the ADHS for medical expenses. The recipient subsequently settled with alleged tortfeasors for approximately one sixth of her damages which, in addition to medical expenses, included future expenses, permanent injury, and lost earnings. The recipient contended that the ADHS was only entitled to claim the portion of the settlement attributable to medical expenses, but the ADHS asserted that Ark. Code Ann. § 20-77-301 et seq. entitled the ADHS to recover from the settlement the full amount it paid in medical expenses. The U.S. Supreme Court unanimously held that federal Medicaid law concerning third-party liability did not authorize the ADHS to recover an amount in excess of the recipient's recovery for medical expenses, and that the federal anti-lien provisions affirmatively prohibited such recovery by the ADHS. Federal laws requiring the recipient to assign payments from third parties only extended to payments for medical care and did not allow ADHS to collect the full amount of benefits paid, and the ADHS was federally precluded from asserting a lien on the settlement for the full amount.

OUTCOME: The judgment which precluded the ADHS from recovering from the settlement the full amount of benefits paid was affirmed.

CORE TERMS: recipient's, settlement, medical care, medical assistance, reimbursement, medical expenses, anti-lien, federal law, tortfeasor, legal liability, assign, health care, eligibility, right to recover, amount collected, settlement proceeds, statutory lien, duty to cooperate, assigned, rights to payment, remainder, lost wages, chose in action, earning, settlement negotiations, amicus curiae, satisfaction, manipulation, reimburse, suffering

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LexisNexis(R) Headnotes

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN1] When a Medicaid recipient in the State of Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs--like pain and suffering, lost wages, and loss of future earnings.

Public Health & Welfare Law > Social Security > Medicaid > General Overview
[HN2] The Medicaid program, which provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs, was launched in 1965 with the enactment of Title XIX of the Social Security Act, 42 U.S.C.S. § 1396 et seq. Its administration is entrusted to the Secretary of Health and Human Services who in turn exercises authority through the Centers for Medicare and Medicaid Services.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > General Overview
[HN3] States are not required to participate in Medicaid, but all of them do. The program is a cooperative one; the federal government pays between 50 percent and 83 percent of the costs a state incurs for patient care and, in return, the state pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program. 42 U.S.C.S. § 1396a.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN4] A state agency in charge of Medicaid must take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan. 42 U.S.C.S. § 1396a(a)(25)(A). The agency's obligation extends beyond mere identification, however.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN5] See 42 U.S.C.S. § 1396a(a)(25)(B).

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN6] To facilitate its Medicaid reimbursement from liable third parties, a state must, to the extent that payment has been made under the state plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, have in effect laws under which, to the extent that payment has been made under the state plan for medical assistance for health care items or services furnished to an individual, the state is considered to have acquired the rights of such individual to payment by any other party for such health care items or services. 42 U.S.C.S. § 1396a(a)(25)(H).

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN7] See 42 U.S.C.S. § 1396k(a).

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN8] Any amount collected by a state under an assignment made under 42 U.S.C.S. § 1396k(a) is retained by the state as is necessary to reimburse it for medical assistance payments made on behalf of a Medicaid recipient. § 1396k(b). The remainder of such amount collected is paid to the recipient.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN9] For purposes of Medicaid recovery, a third party is defined by regulation as any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a state plan. 42 C.F.R. § 433.136.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN10] Acting pursuant to third-party liability provisions of federal law, the State of Arkansas allows both the Arkansas Department of Health and Human Services (ADHS) and a Medicaid recipient, either independently or together, to recover the cost of benefits from third parties. Ark. Code Ann. § 20-77-301 et seq. Initially, as a condition of eligibility for Medicaid, an applicant must automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to ADHS to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant. Ark. Code Ann. § 20-77-307(a). Accordingly, when medical assistance benefits are provided to the recipient because of injury, disease, or disability for which another person is liable, ADHS shall have a right to recover from the person the cost of benefits so provided. Ark. Code Ann. § 20-77-301(a). ADHS's suit shall not, however, be a bar to any action upon the claim or cause of action of the recipient. § 20-77-301(b). Indeed, the statute envisions that the recipient will sometimes sue together

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with ADHS, Ark. Code Ann. § 20-77-303, or even alone. If the latter, the assignment described in Ark. Code Ann. § 20-77-307(a) shall be considered a statutory lien on any settlement, judgment, or award received from a third party. § 20-77-307(c)

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN11] See Ark. Code Ann. § 20-77-302(a).

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN12] The Arkansas Supreme Court holds that the Arkansas Department of Health and Human Services has an independent, nonderivative right to recover the cost of benefits from a third-party tortfeasor under Ark. Code Ann. § 20-77-301 even when a Medicaid recipient also sues for recovery of medical expenses.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN13] Given the clear, unambiguous language of Ark. Code Ann. § 20-77-301 et seq., the ability of the Arkansas Department of Health and Human Services (ADHS) to recoup Medicaid payments from third parties or recipients not be restricted by equitable subrogation principles such as the "made whole" rule. By creating an automatic legal assignment which expressly becomes a statutory lien, Ark. Code Ann. § 20-77-307 makes an unequivocal statement that the ADHS's ability to recover Medicaid payments from insurance settlements, if it so chooses, is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN14] Medicaid recipients must, as a condition of eligibility, assign a state any rights to payment for medical care from any third party, 42 U.S.C.S. § 1396k(a) (1)(A), not rights to payment for, for example, lost wages.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN15] A state can fulfill its obligations under the federal Medicaid third-party liability provisions by requiring an assignment of part of, or placing a lien on, a settlement that a Medicaid recipient procures on her own.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN16] The federal Medicaid statute places express limits on a state's powers to pursue recovery of funds it paid on a recipient's behalf. These limitations are contained in 42 U.S.C.S. §§ 1396a(a)(18), 1396p. 42 U.S.C.S. § 1396a(a)(18) requires that the state Medicaid plan comply with 42 U.S.C.S. § 1396p, which in turn prohibits states (except in certain circumstances) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN17] See 42 U.S.C.S. § 1396p.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN18] For purposes of 42 U.S.C.S. § 1396p, "property" is defined by regulation as the homestead and all other personal and real property in which the recipient has a legal interest. 42 C.F.R. § 433.36(b) (2005).

Contracts Law > Secured Transactions > Application & Construction > Definitions
[HN19] A lien typically is imposed on the property of another for payment of a debt owed by that other.

Public Health & Welfare Law > Social Security > Medicaid > State Plans > Third Party Claims
[HN20] Normally, if a state recovers from a third party the cost of Medicaid benefits paid on behalf of a recipient, the federal government owes the state no reimbursement, and any funds already paid by the federal government must be returned. 42 C.F.R. § 433.140(a)(2) (2005).

Public Health & Welfare Law > Social Security > Medicaid > Medicaid Act Interpretation
[HN21] Congress delegates broad regulatory authority to the Secretary of Health and Human Services in the Medicaid area, and agency adjudications typically warrant deference.

DECISION: **[***459]** State's assertion of lien on Medicaid recipient's tort settlement in amount exceeding stipulated medical-expenses portion held (1) not authorized by federal Medicaid law, and (2) prohibited by federal Medicaid statutes' general anti-lien provision (42 U.S.C.S. § 1396p).

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SUMMARY: The federal Medicaid statutes (42 U.S.C.S. §§ 1396 et seq.) (1) in § 1396a(a)(25)(A), required participating states to ascertain the legal liability of third parties to pay for a benefits recipient's care available under the state's Medicaid; (2) in § 1396a(a)(25)(B), required participating states to seek reimbursement for medical assistance to the extent of such legal liability; and (3) in §§ 1396a(a)(25)(H) and 1396k, provided participating states the right to recover their Medicaid payments to the extent that they were for a recipient's expenses covered by payments from third parties.

When an Arkansas Medicaid recipient obtained a tort settlement following payment of medical costs on the recipient's behalf, an Arkansas statute (1) automatically imposed on the settlement a lien in an amount equal to the state's Medicaid payments; and (2) for satisfaction of such a lien, required payment from proceeds intended to compensate the recipient for damages distinct from medical costs--such as pain and suffering, lost wages, and loss of future earnings--when Medicaid payments exceeded the portion of the settlement that represented medical costs.

An Arkansas department, under the state's Medicaid program, paid $215,645.30 in medical expenses for a Medicaid recipient who was injured in an automobile accident. As a result of the accident, the recipient filed, in a state court, a suit against two alleged tortfeasors for asserted damages for medical costs and for other items including pain and suffering, lost earnings, and permanent impairment of future earning ability. Negotiations, **[***460]** in which the state did not participate or ask to participate, resulted in the case being settled out of court for $550,000, which was not allocated among categories of damages.

After the state asserted a $215,645.30 lien against the settlement proceeds, the recipient filed, in the United States District Court for the Eastern District of Arkansas, an action seeking a declaration that the state's lien violated federal law insofar as the lien's satisfaction would require depletion of compensation for her injuries other than medical expenses. The parties stipulated that (1) the settlement amounted to approximately one-sixth of the reasonable value of the recipient's claim; and (2) if her construction of federal law was correct, the state would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical expenses.

The District Court granted the state summary judgment. However, the United States Court of Appeals for the Eighth Circuit (1) determined that the state was entitled to only that portion of the settlement that represented past medical expenses; and (2) reversed the District Court's judgment (397 F. 3d 620).

On certiorari, the United States Supreme Court affirmed. In an opinion by Stevens, J., expressing the unanimous view of the court, it was held that the state's assertion of the statutory lien, in an amount exceeding the portion of the settlement that had been stipulated by the state as representing compensation for medical expenses, was not authorized by federal Medicaid law and was prohibited by the federal Medicaid statutes' general anti-lien provision (42 U.S.C.S. § 1396p), as:

(1) The state statute (a) found no support in the federal third-party liability provisions; and (b) squarely conflicted with § 1396p, which prohibited states (except in circumstances not relevant in the instant case) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient.

(2) The exception to the anti-lien provision that was carved out by §§ 1396a(a)(25) and 1396k was limited to third-party payments for medical care.

(3) The fact that the state statute referred to the lien that the statute imposed as an "assignment" did not alter the analysis.

LAWYERS' EDITION HEADNOTES:

[*LEdHN1]**

POVERTY AND WELFARE LAWS §8

-- Medicaid -- costs paid by state -- recovery from tort settlement

Headnote: [1A][1B][1C][1D][1E][1F][1G][1H]

A state's assertion, pursuant to a state statute, of a lien on a Medicaid recipient's tort settlement, in an amount exceeding the portion of the settlement that had been stipulated by the state as representing compensation for medical expenses, was not authorized by federal Medicaid law and was prohibited by the federal Medicaid statutes' general anti-lien provision (42 U.S.C.S. § 1396p), as:

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(1) The federal Medicaid statutes (42 U.S.C.S. §§ 1396 et seq.), in some [***461] third-party liability provisions, (a) in § 1396a(a)(25)(A), required participating states to ascertain the legal liability of third parties to pay for a benefits recipient's care available under the state's Medicaid program; (b) in § 1396a(a)(25)(B), required participating states to seek reimbursement for medical assistance to the extent of such legal liability; and (c) in §§ 1396a(a)(25)(H) and 1396k, provided participating states the right to recover their Medicaid payments to the extent that they were for a recipient's expenses covered by payments from third parties.

(2) The state in question, under the state's Medicaid program, paid $215,645.30 in medical expenses for the recipient, who (a) was injured in an automobile accident; (b) filed, in a state court, a suit against two alleged tortfeasors for asserted damages for medical costs and for other items including pain and suffering, lost earnings, and permanent impairment of future earning ability; and (c) settled the state suit out of court for $550,000, which was not allocated among categories of damages.

(3) The recipient and the state stipulated that (a) the settlement amounted to approximately one-sixth of the reasonable value of the recipient's claim; and (b) if her construction of federal law was correct, the state would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical expenses.

(4) The state statute (a) found no support in the federal third-party liability provisions; and (b) squarely conflicted with § 1396p, which prohibited states (except in circumstances not relevant in the instant case) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient.

(5) The exception to the anti-lien provision that was carved out by §§ 1396a(a)(25) and 1396k was limited to third-party payments for medical care.

(6) The fact that the state statute referred to the lien that the statute imposed as an "assignment" did not alter the analysis.

[*LEdHN2]**

POVERTY AND WELFARE LAWS §8

-- tort settlement -- stipulated expenses -- state's recovery of Medicaid payments

Headnote: [2A][2B][2C]

For purposes of determining whether a state's assertion, pursuant to a state statute, of a $215,645.30 lien on a Medicaid recipient's $550,000 tort settlement concerning an automobile accident comported with federal law, the effect of the state's stipulation that only $35,581.47 of the recipient's overall damages represented compensation for medical expenses was the same as if a trial judge had found that the recipient's damages amounted to $3,040,708.12 (of which $215,645.30 were for medical expenses), but that because of her contributory negligence, she could only recover one-sixth of those damages, where:

(1) The state (a) under the state's Medicaid plan, paid $215,645.30 in medical expenses for the recipient; and (b) did not participate or ask to participate in the settlement negotiations.

(2) The recipient sued two alleged tortfeasors in state court for asserted damages for (a) past medical costs; (b) permanent physical injury; (c) future medical expenses; (d) past and future pain, suffering, and mental anguish; (e) past loss of earnings and **[***462]** working time; and (f) permanent impairment of future earning ability.

(3) The tortfeasors accepted responsibility for only one-sixth of the recipient's overall damages.

(4) The recipient and the tortfeasors did not allocate the settlement among categories of damages.

(5) The recipient and the state stipulated that (a) the recipient's entire claim was reasonably valued at $3,040,708.12; (b) the settlement amounted to approximately one-sixth of that sum; and (c) if the recipient's construction of federal law was correct, then the state would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments.

[*LEdHN3]**

POVERTY AND WELFARE LAWS §8

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-- Medicaid -- costs paid by state -- recovery -- lien

Headnote: [3]

For purposes of determining whether Medicaid's general anti-lien provision (42 U.S.C.S. § 1396p) prohibited a state's assertion, pursuant to a state statute, of a lien on a Medicaid recipient's tort settlement in an amount exceeding the portion of the settlement that had been stipulated by the state as representing compensation for medical expenses, although the state statute denominated an "assignment," the state in effect, and as at least some of the language of the state statute recognized, had imposed a lien on the recipient's property, as the statute did not divest the recipient of all of her property interest, for (1) she retained the right to sue for medical-care payments, and (2) the state asserted a right to the fruits of that suit once the fruits materialized.

[*LEdHN4]**

POVERTY AND WELFARE LAWS §8

-- Medicaid -- costs paid by state -- recovery -- lien

Headnote: [4]

For purposes of determining whether a state's assertion of a lien on a Medicaid recipient's tort settlement, in an amount exceeding the portion of the settlement that had been stipulated as representing compensation for medical expenses, comported with federal law, the United States Supreme Court rejected as unpersuasive two arguments--that even if a lien on more than medical damages would have violated federal law in some cases, a rule permitting such a lien ought to apply in the instant case either because (1) the Medicaid recipient in question had breached her duty to "cooperate" with the state, or (2) there was an inherent danger of manipulation in cases where the parties to a tort case settled without judicial oversight or input from a state--as:

(1) The duty to cooperate strayed far beyond the text of the federal Medicaid statutes (42 U.S.C.S. §§ 1396 et seq.) and the relevant federal administrative regulations.

(2) In any event, whatever the bounds of the duty to cooperate, there was no evidence that the recipient had breached this duty.

(3) The risk that parties to a tort suit would allocate away a state's interest could be avoided either by obtaining the state's advance agreement to an allocation, or, if necessary, by submitting the matter to a court for decision, for just as there were risks in underestimating the value of readily calculable damages in settlement negotiations, so also was there a countervailing concern that a rule **[***463]** of absolute priority might (a) preclude settlement in a large number of cases, and (b) be unfair to the Medicaid recipient in others.

[*LEdHN5]**

STATUTES §162.5

-- administrative construction -- Medicaid statutes

Headnote: [5A][5B]

For purposes of determining, under the federal Medicaid statutes (42 U.S.C.S. §§ 1396 et seq.), whether a state's assertion of a lien on a Medicaid recipient's tort settlement, in an amount exceeding the portion of the settlement that had been stipulated as representing compensation for medical expenses, comported with federal law, the United States Supreme Court declined to treat as controlling the opinions of the Departmental Appeals Board of the United States Department of Health and Human Services in two cases in which the Board rejected states' appeals from denials of reimbursement for costs paid on behalf of Medicaid recipients who had settled tort claims, as the Board's opinions in those cases (1) addressed a different question from the one posed in the instant case, and (2) rested on a questionable construction of federal law.

[*LEdHN6]**

POVERTY AND WELFARE LAWS §9

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-- Medicaid -- eligibility

Headnote: [6]

Congress, in crafting the federal Medicaid statutes (42 U.S.C.S. §§ 1396 et seq.), intended that Medicaid be a payer of last resort.

[*LEdHN7]**

STATUTES §162.5

-- administrative construction -- Medicaid statutes

Headnote: [7]

With respect to the federal Medicaid statutes (42 U.S.C.S. §§ 1396 et seq.), (1) Congress has delegated broad regulatory authority to the United States Secretary of Health and Human Services (HHS), and (2) HHS adjudications typically warrant judicial deference. **[***464]**

SYLLABUS

Federal Medicaid law requires participating States to "ascertain the legal liability of third parties . . . to pay for [an individual benefits recipient's] care and services available under the [State's] plan," 42 U.S.C. § 1396a(a)(25)(A); to "seek reimbursement for [medical] assistance to the extent of such legal liability," 1396a(a)(25)(B); to enact "laws under which, to the extent that payment has been made . . . for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services," § 1396a(a)(25)(H); to "provide that, as a condition of [Medicaid] eligibility . . ., the individual is required . . . (A) to assign the State any rights . . . to payment for medical care from any third party; . . . (B) to cooperate with the State . . . in obtaining [such] payments . . . and . . . (C) . . . in identifying, and providing information to assist the State in pursuing, any third party who may be liable," 1396k(a)(1). Finally, "any amount collected by the State under an assignment made" as described above "shall be retained by the State . . . to reimburse it for [Medicaid] payments made on behalf of" the recipient. § 1396k(b). "[T]he remainder of such amount collected shall be paid" to the recipient. *Ibid.* Acting pursuant to its understanding of these provisions, Arkansas passed laws under which, when a state Medicaid recipient obtains a tort settlement following payment of medical costs on her behalf, a lien is automatically imposed on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement representing medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs, such as pain and suffering, lost wages, and loss of future earnings.

Following respondent Ahlborn's car accident with allegedly negligent third parties, petitioner Arkansas Department of Health and Human Services, then named Arkansas Department of Human Services (ADHS), determined that Ahlborn was eligible for Medicaid and paid providers $215,645.30 on her behalf. She filed a state-court suit against the alleged tortfeasors seeking damages for past medical costs and for other items including pain and suffering, loss of earnings and working time, and permanent impairment of her future earning ability. The case was settled out of court for $550,000, which was not allocated between categories of damages. ADHS did not participate or ask to participate in the settlement negotiations, and did not seek to reopen the judgment after the case was dismissed, but did intervene in the suit and assert a lien against the settlement proceeds for the full amount it had paid for Ahlborn's care. She filed this action in Federal District Court seeking a declaration that the State's lien violated **[***465]** federal law insofar as its satisfaction would require depletion of compensation for her injuries other than past medical expenses. The parties stipulated, *inter alia,* that the settlement amounted to approximately one-sixth of the reasonable value of Ahlborn's claim and that, if her construction of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made. In granting ADHS summary judgment, the court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned ADHS her right to recover the full amount of Medicaid's payments for her benefit. The Eighth Circuit reversed, holding that ADHS was entitled only to that portion of the settlement that represented payments for medical care.

Held:

Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are

unenforceable insofar as they compel a different conclusion.

(a) Arkansas' statute finds no support in the federal third-party liability provisions. That ADHS cannot claim more than the portion of Ahlborn's settlement that represents medical expenses is suggested by § 1396k(a)(1)(A), which requires that Medicaid recipients, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party" (emphasis added), not their rights to payment for, *e.g.,* lost wages. The other statutory language ADHS relies on is not to the contrary, but reinforces the assignment provision's implicit limitation. First, statutory context shows that § 1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance *to the extent of such legal liability*" refers to "the legal liability of third parties . . . *to pay for care and services available under the plan,*" § 1396a(a)(25)(A) (emphases added). Here, because the tortfeasors accepted liability for only one-sixth of Ahlborn's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents compensation for medical expenses, the relevant "liability" extends no further than that amount. Second, § 1396a(a)(25)(H)'s requirement that the State enact laws giving it the right to recover from liable third parties "to the extent [it made] payment . . . for medical assistance for health care items or services furnished to an individual" does not limit the State's recovery only by the amount it paid out on the recipient's behalf, since the rest of the provision makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services.*" (Emphasis added.) Finally, § 1396k(b)'s requirement that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient does not show that the State must be paid in full from any settlement. Rather, because the State's assigned rights extend only to recovery of medical payments, what § 1396k(b) requires is that the State be paid first out of any damages for medical care before the recipient **[***466]** can recover any of her own medical costs.

(b) Arkansas' statute squarely conflicts with the federal Medicaid law's anti-lien provision, § 1396p(a)(1), which prohibits States from imposing liens "against the property of any individual prior to his death on account of medical assistance paid . . . on his behalf under the State plan." Even if the State's lien is assumed to be consistent with federal law insofar as it encumbers proceeds designated as medical payments, the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement. ADHS' attempt to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property," but as the State's, fails for two reasons. First, because the settlement is not "received from a third party," as required by the state statute, until Ahlborn's chose in action has been reduced to proceeds in her possession, the assertion that any of the proceeds belonged to the State all along lacks merit. Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory lien on those proceeds: ADHS would not need a lien on its own property.

(c) The Court rejects as unpersuasive ADHS' and the United States' arguments that a rule permitting a lien on more than medical damages ought to apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. As § 1396k(a)(1)(C) demonstrates, the duty to cooperate arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties. In any event, the aspersions cast upon Ahlborn are entirely unsupported; all the record reveals is that ADHS neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here. Although more colorable, the alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation also fails. The risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.

(d) Also rejected is ADHS' contention that the Eighth Circuit accorded insufficient weight to two decisions by the Departmental Appeals Board (Board) of the federal Department of Health and Human Services (HHS) rejecting appeals by two States from denial of reimbursement for costs they paid on behalf of Medicaid recipients who had settled tort claims. Although HHS generally has broad regulatory authority in the Medicaid area, the Court declines to treat the Board's reasoning in those cases as controlling because they address a different question from the one posed here, make no mention of the anti-lien provision, and rest on a questionable construction of the federal third-party liability provisions.

397 F.3d 620, affirmed.

COUNSEL: Lori Freno argued the cause for petitioners.

H. David Blair argued the cause for the United States, as amicus curiae, by special leave of court.

Patricia A. Millett argued the cause for respondent.

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JUDGES: Stevens, J., delivered the opinion for a unanimous Court.

OPINION BY: STEVENS

OPINION

[*272] [*467] [**1756]** Justice **Stevens** delivered the opinion of the Court.

[HN1] [1A] When a Medicaid recipient in Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs--like pain and suffering, lost wages, and loss of future earnings. The Court of Appeals for the Eighth Circuit held that this statutory lien contravened federal law and was therefore unenforceable. *Ahlborn* v. *Ark. Dep't of Human Servs.*, 397 F.3d 620 (2005). Other courts have upheld similar lien provisions. See, *e.g.*, *Houghton* v. *Dep't of Health*, 2002 UT 101, 57 P.3d 1067; *Wilson* v. *State*, 142 Wn.2d 40, 10 P.3d 1061 **[**1757]** (2000) (en banc). We granted certiorari to resolve the conflict, 545 U.S. 1165, 126 S. Ct. 35, 162 L. Ed. 2d 933 (2005), and now affirm.

I

[*LEdHR2A]** [2A] On January 2, 1996, respondent Heidi Ahlborn, then a 19-year-old college student and aspiring teacher, suffered severe **[*273]** and permanent injuries as a result of a car accident. She was left brain damaged, unable to complete her college education, and incapable of pursuing her chosen career. Although she possessed a claim of uncertain value against the alleged tortfeasors who caused her injuries, Ahlborn's liquid assets were insufficient to pay for her medical care. Petitioner Arkansas Department of Health and Human Services (ADHS) [1] accordingly determined that she was eligible for medical assistance and paid providers $215,645.30 on her behalf under the State's Medicaid plan.

1 ADHS was then named Arkansas Department of Human Services.

ADHS required Ahlborn to complete a questionnaire about her accident, and sent her attorney periodic letters advising him about Medicaid outlays. These letters noted that, under Arkansas law, ADHS had a claim to reimbursement from "any settlement, judgment, or award" obtained by Ahlborn from "a third party who may be liable for" her injuries, and that no settlement "shall be satisfied without first giving [ADHS] notice and a reasonable opportunity to establish its interest." [2] ADHS has never asserted, however, that Ahlborn has a duty to reimburse it out of any other subsequently acquired assets or earnings.

2 Affidavit of Wayne E. Olive, Exhs. 5 and 6 (Mar. 6, 2003).

On April 11, 1997, Ahlborn filed suit against two alleged tortfeasors in Arkansas state court seeking compensation for the injuries she sustained in the January 1996 car accident. She claimed damages not only for past medical costs, but also for permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future.

ADHS was neither named as a party nor formally notified of the suit. Ahlborn's counsel did, however, keep ADHS informed of details concerning **[***468]** insurance coverage as they became known during the litigation.

[*274] In February 1998, ADHS intervened in Ahlborn's lawsuit to assert a lien on the proceeds of any third-party recovery Ahlborn might obtain. In October 1998, ADHS asked Ahlborn's counsel to notify the agency if there was a hearing in the case. No hearing apparently occurred, and the case was settled out of court sometime in 2002 for a total of $550,000. The parties did not allocate the settlement between categories of damages. ADHS did not participate or ask to participate in settlement negotiations. Nor did it seek to reopen the judgment after the case had been dismissed. ADHS did, however, assert a lien against the settlement proceeds in the amount of $215,645.30--the total cost of payments made by ADHS for Ahlborn's care.

On September 30, 2002, Ahlborn filed this action in the United States District Court for the Eastern District of Arkansas seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses. To facilitate the District Court's resolution of the legal questions

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presented, the parties stipulated that Ahlborn's entire claim was reasonably valued at $3,040,708.12; that the settlement amounted to approximately one-sixth of that sum; and that, if Ahlborn's construction **[**1758]** of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made. See App. 17-20.

Ruling on cross-motions for summary judgment, the District Court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned to ADHS her right to any recovery from the third-party tortfeasors to the full extent of Medicaid's payments for her benefit. Accordingly, ADHS was entitled to a lien in the amount of $215,645.30.

[*275] The Eighth Circuit reversed. It held that ADHS was entitled only to that portion of the judgment that represented payments for medical care. For the reasons that follow, we affirm.

II

The crux of the parties' dispute lies in their competing constructions of the federal Medicaid laws. [HN2] The Medicaid program, which provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs, was launched in 1965 with the enactment of Title XIX of the Social Security Act (SSA), as added, 79 Stat. 343, 42 U.S.C. § 1396 et seq. (2000 ed. and Supp. III). Its administration is entrusted to the Secretary of Health and Human Services (HHS), who in turn exercises his authority through the Centers for Medicare and Medicaid Services (CMS). [3]

3 Until 2001, CMS was known as the Health Care Financing Administration or HCFA. See 66 Fed. Reg. 35437.

[HN3] States are not required to participate in Medicaid, but all of them do. The program is a cooperative one; the Federal Government pays between 50% and 83% of the costs the **[***469]** State incurs for patient care, [4] and, in return, the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program. See § 1396a.

4 The exact percentage of the federal contribution is calculated pursuant to a formula keyed to each State's per capita income. See 42 U.S.C. § 1396d(b).

[*LEdHR1B]** [1B] One such requirement is that [HN4] the state agency in charge of Medicaid (here, ADHS) "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan." § 1396a(a)(25)(A) (2000 ed.). [5] **[*276]** The agency's obligation extends beyond mere identification, however;

[HN5] "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability." § 1396a(a)(25)(B).

[HN6] To facilitate its reimbursement from liable third parties, the State must,

"to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, [have] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to **[**1759]** have acquired the rights of such individual to payment by any other party for such health care items or services." § 1396a(a)(25)(H).

The obligation to enact assignment laws is reiterated in another provision of the SSA, which reads as follows:

[HN7] "(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall--

"(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who **[*277]** has the legal capacity to execute an assignment for himself, the individual is required--

"(A) to assign the State any rights . . . to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

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"(B) to cooperate with the State . . . in obtaining support and payments (described in subparagraph (A)) for himself . . .; and

"(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services [***470] available under the plan . . . ." § 1396k(a).

Finally, [HN8] "any amount collected by the State under an assignment made" as described above "shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of" the Medicaid recipient. § 1396k(b). "[T]he remainder of such amount collected shall be paid" to the recipient. *Ibid.*

5 [HN9] A "third party" is defined by regulation as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan." 42 CFR § 433.136 (2005).

[HN10] Acting pursuant to its understanding of these third-party liability provisions, the State of Arkansas passed laws that purport to allow both ADHS and the Medicaid recipient, either independently or together, to recover "the cost of benefits" from third parties. Ark. Code Ann. §§ 20-77-301 through 20-77-309 (2001). Initially, "[a]s a condition of eligibility" for Medicaid, an applicant "shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." § 20-77-307(a). Accordingly, "[w]hen medical assistance benefits are provided" to the recipient "because of injury, disease, or disability for which another person is liable," ADHS "shall have a right to recover from the person the cost of benefits so provided." § 20-77-301(a). [6] [*278] ADHS' suit "shall" not, however, "be a bar to any action upon the claim or cause of action of the recipient." § 20-77-301(b). Indeed, the statute envisions that the recipient will sometimes sue together with ADHS, see § 20-77-303, or even alone. If the latter, the assignment described in § 20-77-307(a) "shall be considered a statutory lien on any settlement, judgment, or award received . . . from a third party." § 20-77-307(c); see also § 20-77-302(a) [HN11] ("When an action or claim is brought by a medical assistance recipient . . ., any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under [**1760] the medical assistance program"). [7]

6 Under the Arkansas statute, ADHS' right to recover medical costs appears to be broader than that of the recipient. When ADHS sues, "no contributory or comparative fault of a recipient shall be attributed to the state, nor shall any restitution awarded to the state be denied or reduced by any amount or percentage of fault attributed to a recipient." § 20-77-301(d)(1) (2001).

7 [HN12] The Arkansas Supreme Court has held that ADHS has an independent, nonderivative right to recover the cost of benefits from a third-party tortfeasor under § 20-77-301 even when the Medicaid recipient also sues for recovery of medical expenses. See *National Bank of Commerce* v. *Quirk*, 323 Ark. 769, 792-794, 918 S.W.2d 138, 151-152 (1996).

The State, through this statute, claims an entitlement to more than just that portion of a judgment or settlement that represents payment for medical expenses. It claims a right to recover the entirety of the costs it paid on the Medicaid recipient's behalf. Accordingly, if, for example, a recipient sues alone and settles her entire action against a third-party tortfeasor for $20,000, and ADHS has paid that amount or more to medical providers on her behalf, ADHS gets the whole settlement and the recipient is left with nothing. This is so even when the parties to the settlement allocate damages between medical costs, on the one hand, and other injuries like lost wages, on the other. The same rule also [*279] would apply, it seems, if the recovery were the result not of a [***471] settlement but of a jury verdict. In that case, under the Arkansas statute, ADHS could recover the full $20,000 in the face of a jury allocation of, say, only $10,000 for medical expenses. [8]

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8 ADHS denies that it would actually demand the full $20,000 in such a case, see Brief for Petitioners 49, n 13, but points to no provision of the Arkansas statute that would prevent it from doing so.

That this is what the Arkansas statute requires has been confirmed by the State's Supreme Court. In *Arkansas Dep't of Human Servs.* v. *Estate of Ferrel*, 336 Ark. 297, 984 S.W.2d 807 (1999), the court refused to endorse an equitable, nontextual interpretation of the statute. Rejecting a Medicaid recipient's argument that he ought to retain some of a settlement that was insufficient to cover both his and Medicaid's expenses, the court explained:

[HN13] "Given the clear, unambiguous language of the statute, it is apparent that the legislature intended that ADHS's ability to recoup Medicaid payments from third parties or recipients not be restricted by equitable subrogation principles such as the 'made whole' rule stated in [*Franklin* v. *Healthsource of Arkansas*, 328 Ark. 163, 942 S.W.2d 837 (1997)]. By creating an automatic legal assignment which expressly becomes a statutory lien, [Ark. Code Ann. § 20-77-307 (1991)] makes an unequivocal statement that the ADHS's ability to recover Medicaid payments from insurance settlements, if it so chooses, is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs. " *Id.*, at 308, 984 S. W. 2d, at 811.

Accordingly, the Arkansas statute, if enforceable against Ahlborn, authorizes imposition of a lien on her settlement proceeds in the amount of $215,645.30. Ahlborn's argument before the District Court, the Eighth Circuit, and this Court **[*280]** has been that Arkansas law goes too far. We agree. Arkansas' statute finds no support in the federal third-party liability provisions, and in fact squarely conflicts with the anti-lien provision of the federal Medicaid laws.

III

[*LEdHR1C]** [1C] We must decide whether ADHS can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses. [9] The text of the federal **[**1761]** third-party liability provisions suggests not; it focuses on recovery of payments for medical care. [HN14] Medicaid recipients must, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party," 42 U.S.C. § 1396k(a)(1)(A) (emphasis added), not rights to payment for, for example, lost wages. The other statutory language that ADHS relies upon is not to the contrary; indeed, it reinforces the limitation implicit in the assignment provision.

9 The parties here assume, as do we, that [HN15] a State can fulfill its obligations under the federal third-party liability provisions by requiring an "assignment" of part of, or placing a lien on, the settlement that a Medicaid recipient procures on her own. Cf. §§ 1396k(a)(1)(B)-(C) (the recipient has a duty to identify liable third parties and to "provid[e] information to *assist the State in pursuing*" those parties (emphasis added)).

[*LEdHR1D]** [1D] **[***LEdHR2B]** [2B] First, ADHS points to § 1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance *to the extent of* **[***472]** *such legal liability*" (emphasis added) and suggests that this means that the entirety of a recipient's settlement is fair game. In fact, as is evident from the context of the emphasized language, "such legal liability" refers to "the legal liability of third parties . . . *to pay for care and services available under the plan.*" § 1396a(a)(25)(A) (emphasis added). Here, the tortfeasor has accepted liability for only one-sixth of the recipient's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, **[*281]** the relevant "liability" extends no further than that amount. [10]

10 **[***LEdHR2C]** [2C] The effect of the stipulation is the same as if a trial judge had found that Ahlborn's damages amounted to $3,040,708.12 (of which $215,645.30 were for medical expenses), but because of her contributory negligence, she could only recover one-sixth of those damages.

[*LEdHR1E]** [1E] Second, ADHS argues that the language of § 1396a(a)(25)(H) favors its view that it can demand full reimbursement of its costs from Ahlborn's settlement. That provision, which echoes the requirement of a mandatory assignment of rights in § 1396k(a), says that the State must have in effect laws that, "to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual," give the State the right to recover from liable third parties. This must mean, says ADHS, that the agency's recovery is limited only by the amount it paid out on the recipient's behalf--and not by the third-party tortfeasor's particular liability for medical expenses. But that reading ignores the rest of the provision, which makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services.*" § 1396a(a)(25)(H) (emphasis added). Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses--not lost wages, not pain and suffering, not an inheritance.

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Finally, ADHS points to the provision requiring that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient. § 1396k(b). In ADHS' view, this shows that the State must be paid in full from any settlement. See Brief for Petitioners 13. But, even assuming the provision applies in cases where the State does not actively participate in the litigation, ADHS' conclusion rests on a false premise: The **[*282]** "amount recovered . . . under an assignment" is not, as ADHS assumes, the entire settlement; as explained above, under the federal statute the State's assigned rights extend only to recovery of payments **[**1762]** for medical care. Accordingly, what § 1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care. [11]

11 Implicit in ADHS' interpretation of this provision is the assumption that there can be no "remainder" to remit to the Medicaid recipient if all the State has been assigned is the right to damages for medical expenses. That view in turn seems to rest on an assumption either that Medicaid will have paid all the recipient's medical expenses or that Medicaid's expenses will always exceed the portion of any third-party recovery earmarked for medical expenses. Neither assumption holds up. First, as both the Solicitor General and CMS acknowledge, the recipient often will have paid medical expenses out of her own pocket. See Brief for United States as *Amicus Curiae* 12 (under § 1396k(b), "the beneficiary retains the right to payment for any additional medical expenses personally incurred either before or subsequent to Medicaid eligibility and for other damages"); CMS, State Medicaid Manual § 3907, available at https://www.lexis.com>Legal>Secondary Legal>CCH>Health Law>CMS Program Manuals>CCH CMS Program Manuals P 3907 (as updated Mar. 25, 2006, and available in Clerk of Court's case file) (envisioning that "medical insurance payments," for example, will be remitted to the recipient if possible). Second, even if Medicaid's outlays often exceed the portion of the recovery earmarked for medical expenses in tort cases, the third-party liability provisions were not drafted exclusively with tort settlements in mind. In the case of health insurance, for example, the funds available under the policy may be enough to cover both Medicaid's costs and the recipient's own medical expenses.

At the very least, then, the federal **[***473]** third-party liability provisions *require* an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care. [12] They did not mandate the enactment of the Arkansas scheme that we have described.

12 ADHS concedes that, had a jury or judge allocated a sum for medical payments out of a larger award in this case, the agency would be entitled to reimburse itself only from the portion so allocated. See Brief for Petitioners 49, n 13; see also Brief for United States as *Amicus Curiae* 22, n 14 (noting that the Secretary of HHS "ordinarily accepts" a jury allocation of medical damages in satisfaction of the Medicaid debt, even where smaller than the amount of Medicaid's expenses). Given the stipulation between ADHS and Ahlborn, there is no textual basis for treating the settlement here differently from a judge-allocated settlement or even a jury award; all such awards typically establish a third party's "liability" for both "payment for medical care" and other heads of damages.

[*283] IV

[*LEdHR1F]** [1F] If there were no other relevant provisions in the federal statute, the State might plausibly argue that federal law supplied a recovery "floor" upon which States were free to build. In fact, though, [HN16] the federal statute places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf. These limitations are contained in 42 U.S.C. §§ 1396a(a)(18) and 1396p. Section 1396a(a)(18) requires that a state Medicaid plan comply with § 1396p, which in turn prohibits States (except in circumstances not relevant here) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient:

[HN17] "(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

"(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except--

"(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

"(B) [in certain circumstances not relevant here]

. . . . .

"(b) Adjustment or recovery of medical assistance correctly paid under a State plan

[1763]** "(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the **[*284]** State plan may be made, except [in circumstances not relevant here]." § 1396p.

Read literally and in isolation, the anti-lien prohibition contained in § 1396p(a) would appear to ban even a lien on that portion of the settlement **[***474]** proceeds that represents payments for medical care. [13] Ahlborn does not ask us to go so far, though; she assumes that the State's lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement.

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13 Likewise, subsection (b) would appear to forestall any attempt by the State to recover benefits paid, at least from the "individual." See, *e.g.*, *Martin ex rel. Hoff* v. *Rochester*, 642 N.W.2d 1, 8, n. 6 (Minn. 2002); *Wallace* v. *Estate of Jackson*, 972 P.2d 446, 450 (Utah 1998) (Durham, J.,

dissenting) (reading § 1396p to "prohibi[t] not only liens against Medicaid recipients but also any recovery for medical assistance correctly paid"). The parties here, however, neither cite nor discuss the antirecovery provision of § 1396p(b). Accordingly, we leave for another day the question of its impact on the analysis.

We agree. There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§ 1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. See *Wash. State Dep't of Soc. & Health Servs.* v. *Guardianship Estate of Keffeler*, 537 U.S. 371, 383-385, and n. 7, 123 S. Ct. 1017, 154 L. Ed. 2d 972 (2003). But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by **[*285]** §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.

ADHS tries to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property." [14] Its argument appears to be that the automatic assignment effected by the Arkansas statute rendered the proceeds the property of the State. [15] See Brief for Petitioners 31 ("[U]nder Arkansas law, the lien does not attach to the recipient's 'property' because it attaches only to those proceeds already assigned to the Department as a condition of Medicaid eligibility"). That argument fails for two reasons.

14 [HN18] "Property" is defined by regulation as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 CFR § 433.36(b) (2005).

15 The United States as *amicus curiae* makes the different argument that the proceeds never became Ahlborn's "property" because "to the extent the third party's payment passes through the recipient's hands en route to the State, it comes with the State's lien already attached." Brief as *Amicus Curiae* 18. Even if that reading were consistent with the Arkansas statute (and it is not, see *infra* this page), the United States' characterization of the "assignment" simply reinforces Ahlborn's point: This is a lien that attaches *to the property of the recipient.*

First, ADHS insists that Ahlborn at all times until judgment retained her entire chose in action--a right that included her claim for medical damages. The statutory lien, then, cannot have attached until the proceeds materialized. That much is clear **[**1764]** from the text of the Arkansas statute, which says that the "assignment shall be considered a statutory lien on any settlement . . . *received by the recipient from a third party.*" **[***475]** Ark. Code Ann. § 20-77-307(c) (2001) (emphasis added). The settlement is not "received" until the chose in action has been reduced to proceeds in Ahlborn's possession. Accordingly, the assertion that any of the proceeds belonged to the State all along lacks merit.

Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory **[*286]** lien on those proceeds. Why, after all, would ADHS need a lien on its own property? [HN19] A lien typically is imposed on the property of *another* for payment of a debt owed by that other. See Black's Law Dictionary 922 (6th ed. 1990). Nothing in the Arkansas statute defines the term otherwise.

[*LEdHR1G]** [1G] **[***LEdHR3]** [3] That the lien is also called an "assignment" does not alter the analysis. The terms that Arkansas employs to describe the mechanism by which it lays claim to the settlement proceeds do not, by themselves, tell us whether the statute violates the anti-lien provision. See *United States* v. *Craft,* 535 U.S. 274, 279, 122 S. Ct. 1414, 152 L. Ed. 2d 437 (2002); *Drye* v. *United States*, 528 U.S. 49, 58-61, 120 S. Ct. 474, 145 L. Ed. 2d 466 (1999). Although denominated an "assignment," the effect of the statute here was not to divest Ahlborn of all her property interest; instead, Ahlborn retained the right to sue for medical care payments, and the State asserted a right to the fruits of that suit once they materialized. In effect, and as at least some of the statutory language recognizes, Arkansas has imposed a lien on Ahlborn's property. [16] Since none of the federal third-party liability provisions excepts that lien from operation of the anti-lien provision, its imposition violates federal law.

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16 Because ADHS insists that "Arkansas law did *not* require Ahlborn to assign her claim or her right to sue," Brief for Petitioners 33 (emphasis in original), we need not reach the question whether a State may force a recipient to assign a chose in action to receive as much of the settlement as is necessary to pay Medicaid's costs. The Eighth Circuit thought this would be impermissible because the State cannot "circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain." App. to Pet. for Cert. 6. Indeed, ADHS acknowledges that Arkansas cannot, for example, require a Medicaid applicant to assign in advance any right she may have to recover an inheritance or an award in a civil case not related to her injuries or medical care. This arguably is no different; as with assignment of those other choses in action, assignment of the right to compensation for lost wages and other nonmedical damages is nowhere authorized by the federal third-party liability provisions.

[*287] V

[***LEdHR4] [4] ADHS and its *amici* urge, however, that even if a lien on more than medical damages would violate federal law in some cases, a rule permitting such a lien ought to apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. Neither argument is persuasive.

The United States proposes a default rule of full reimbursement whenever the recipient breaches her duty to "cooperate," and asserts that [***476] Ahlborn in fact breached that duty. [17] But, even if the Government's [**1765] allegations of obstruction were supported by the record, its conception of the duty to cooperate strays far beyond the text of the statute and the relevant regulations. The duty to cooperate arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties. See 42 U.S.C. § 1396k(a)(1)(C) (recipients must "cooperate with the State in identifying . . . and providing information to assist the State in pursuing" third parties). Most of the accompanying federal regulations simply echo this basic duty; all they add is that the recipient must "[p]ay to the agency any support or medical care funds received that are covered by the assignment of rights." 42 CFR § 433.147(b)(4) (2005).

17 See, *e.g.*, Brief for United States as *Amicus Curiae* 14 (alleging that Ahlborn "omitt[ed] or understat[ed] the medical damages claim from her lawsuit and attempt[ed] to horde for herself the third-party liability payments"); *id.*, at 15 ("[H]aving forsaken her federal and state statutory duties of candid and forthcoming cooperation[,] respondent, rather than the taxpayers, must bear the financial consequences of her actions"); *id.*, at 21, 24 (referring to Ahlborn's "backdoor settlement" and "obstruction and attrition," as well as her "calculated evasion of her legal obligations").

In any event, the aspersions the United States casts upon Ahlborn are entirely unsupported; all the record reveals is that ADHS, despite having intervened in the lawsuit and [*288] asked to be apprised of any hearings, neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here.

ADHS' and the United States' alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation is more colorable, but ultimately also unpersuasive. The issue is not, of course, squarely presented here; ADHS has stipulated that only $35,581.47 of Ahlborn's settlement proceeds properly are designated as payments for medical costs. Even in the absence of such a postsettlement agreement, though, the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision. [18] For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others. [19]

18 As one *amicus* observes, some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers' rights to recovery are at issue. See Brief for Association of Trial Lawyers of America 20-21. Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.

19 The point is illustrated by state cases involving the recovery of workers' compensation benefits paid to an employee (or the family of an employee) whose injuries were caused by a third-party tortfeasor. In *Flanigan* v. *Department of Labor and Industry*, 123 Wn. 2d 418, 869 P.2d 14 (1994), for example, the court concluded that the state agency could not satisfy its lien out of damages the injured worker's spouse recovered as compensation for loss of consortium. The court explained that the department could not "share in damages for which it has provided no compensation" because such a result would be "absurd and fundamentally unjust." *Id.*, at 426, 869 P. 2d, at 17.

[***477] [*289] VI

[***LEdHR5A] [5A] Finally, ADHS contends that the Court of Appeals' decision below accords insufficient weight to two decisions by the Departmental Appeals Board of HHS (Board) rejecting appeals by the States of California and Washington from denial of reimbursement for costs those States paid on [**1766] behalf of Medicaid recipients who had settled tort claims. See App. to Pet. for Cert. 45-67 (reproducing *In re Washington State Dept. of Social & Health Servs.*, Dec. No. 1561, 1996 WL 157123 (HHS Dept. App. Bd., Feb. 7, 1996)); App. to Pet. for Cert. 68-86 (reproducing *In re California Dept. of Health Servs.*, Dec. No. 1504, 1995 WL 66334 (HHS Dept. App. Bd., Jan. 5, 1995)). Because the opinions in those cases address a different question from the one posed here, make no mention of the anti-lien provision, and, in any event, rest on a questionable construction of the federal third-party liability provisions, we conclude that they do not control our analysis.

[HN20] Normally, if a State recovers from a third party the cost of Medicaid benefits paid on behalf of a recipient, the Federal Government owes the State no reimbursement, and any funds already paid by the Federal Government must be returned. See 42 CFR § 433.140(a)(2) (2005) (federal financial participation "is not available in Medicaid payments if . . . [t]he agency received reimbursement from a liable third party"); § 433.140(c). Washington and California both had adopted schemes according to which the State refrained from claiming full reimbursement from tort settlements and instead took only a portion of each settlement. (In California, the recipient typically could keep at least 50% of her settlement, see App. to Pet. for Cert. 72; in Washington, the proportion varied from case to case, see *id.*, at 48-51.) Each scheme resulted in the State's having to pay a portion of the recipient's medical costs--a portion for which the State sought partial reimbursement from the Federal Government. CMS (then called HCFA) denied this partial reimbursement **[*290]** on the ground that the States had an absolute duty to seek full payment of medical expenses from third-party tortfeasors.

The Board upheld CMS' determinations. In California's appeal, which came first, the Board concluded that the State's duty to seek recovery of benefits "from available third party sources to the fullest extent possible" included demanding full reimbursement from the entire proceeds of a Medicaid recipient's tort settlement. *Id.*, at 76. The Board acknowledged that § 1396k(a) "refers to assignment only of 'payment for medical care,'" but thought that "the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first." *Ibid.* The Board gave two other reasons for siding with CMS: First, the legislative history of the third-party liability evinced a congressional intent that "the Medicaid program . . . be reimbursed from available third party sources to the fullest extent possible," *ibid.;* and, second, California had long been on notice that it would not be reimbursed for any shortfall resulting from failure to fully recoup Medicaid's costs from tort settlements, see **[***478]** *id.*, at 77. The Board also opined that the State could not escape its duty to seek full reimbursement by relying on the Medicaid recipient's efforts in litigating her claims. See *id.*, at 79-80.

Finally, responding to the State's argument that its scheme gave Medicaid recipients incentives to sue third-party tortfeasors and thus resulted in both greater recovery and lower costs for the State, the Board observed that "a state is free to allow recipients to retain the state's share" of any recovery, so long as it does not compromise the Federal Government's share. *Id.*, at 85.

The Board reached the same conclusion, by the same means, in the Washington case. See *id.*, at 53-64.

Neither of these adjudications compels us to conclude that Arkansas' statutory **[**1767]** lien comports with federal law. First, the Board's rulings address a different question from the one **[*291]** presented here. The Board was concerned with the Federal Government's obligation to reimburse States that had, in its view, failed to seek full recovery of Medicaid's costs and had instead relied on recipients to act as private attorneys general. The Board neither discussed nor even so much as cited the federal anti-lien provision.

Second, the Board's acknowledgment that the assignment of rights required by § 1396k(a) is limited to payments for medical care only reinforces the clarity of the statutory language. Moreover, its resort to "the statutory scheme as a whole" as justification for muddying that clarity is nowhere explained. Given that the only statutory provisions CMS relied on are §§ 1396a(a)(25), 1396k(a), and 1396k(b), see *id.*, at 75-76; *id.*, at 54-55, and given the Board's concession that the first two of these limit the State's assignment to payments for medical care, the "statutory scheme" must mean § 1396k(b). But that provision does not authorize the State to demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages; instead, it gives the State a priority disbursement from the medical expenses portion alone. See *supra*, at 282, 164 L. Ed. 2d, at 473. In fact, in its adjudication in the Washington case, the Board conceded as much: "[CMS] may require a state to assert a collection priority over funds obtained by Medicaid recipients in [third-party liability] suits *even though the distribution methodology set forth in section [1396k(b)]* refers only to payments collected pursuant to assignments for medical care." App. to Pet. for Cert. 54 (emphasis added). The Board's reasoning therefore is internally inconsistent.

[*LEdHR5B]** [5B] **[***LEdHR6]** [6] **[***LEdHR7]** [7] Third, the Board's reliance on legislative history is misplaced. The Board properly observed that Congress, in crafting the Medicaid legislation, intended that Medicaid be a "payer of last resort." S. Rep. No. 99-146, p 313 (1985). That does not mean, however, that Congress meant to authorize States to seek reimbursement from Medicaid recipients themselves; in fact, with the possible exception of a lien **[*292]** on payments for medical care, the statute expressly prohibits liens against the property of Medicaid beneficiaries. See 42 U.S.C. § 1396p(a). We recognize that [HN21] Congress has delegated "broad regulatory authority to the Secretary [of HHS] in the Medicaid area," *Wisconsin. Dep't of Health & Family Servs.* v. *Blumer*, 534 U.S. 473, 496, n. 13, **[***479]** 122 S. Ct. 962, 151 L. Ed. 2d 935 (2002), and that agency adjudications typically warrant deference. Here, however, the Board's reasoning couples internal inconsistency with a conscious disregard for the statutory text. Under these circumstances, we decline to treat the agency's reasoning as controlling.

VII

[***LEdHR1H] [1H] Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion. The judgment of the Court of Appeals is affirmed.

It is so ordered.

REFERENCES

79 Am Jur 2d, Welfare Laws §§ 83, 85, 86

42 U.S.C.S. §§ 1396a(a)(25), 1396k, 1396p

Health Care Law: A Practical Guide § 7.03 (Matthew Bender 2d ed.)

L Ed Digest, Poverty and Welfare Laws § 8

L Ed Index, Medicaid

Annotation References

Supreme Court's views as to construction and application of Medicaid Act (42 U.S.C.S. §§ 1396-1396s). 85 L. Ed. 2d 935.

Supreme Court's view as to weight and effect to be given, on subsequent judicial construction, to prior administrative construction of statute. 39 L. Ed. 2d 942.

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Chapter 43.20B RCW
Revenue recovery for department of social and health services

RCW Sections

GENERAL PROVISIONS

NONRESIDENTIAL FEES AND COSTS OF SERVICES

RESIDENTIAL SERVICES

200

RECOVERY OF OVERPAYMENTS

CONSTRUCTION

201

RCW 43.20B.410
Residential habilitation centers — Liability for costs of services — Declaration of purpose.

The purpose of RCW 43.20B.410 through 43.20B.455 is to place financial responsibility for cost of care, support and treatment upon those residents of residential habilitation centers operated under chapter 71A.20 RCW who possess assets over and above the minimal amount required to be retained for personal use; to provide procedures for establishing such liability and the monthly rate thereof, and the process for appeal therefrom to the secretary of social and health services and the courts by any person deemed aggrieved thereby.

[1988 c 176 § 902; 1987 c 75 § 23; 1979 c 141 § 237; 1967 c 141 § 1. Formerly RCW 72.33.650.]

Notes:

Severability -- 1988 c 176: See RCW 71A.10.900.

Effective date -- 1967 c 141: "This 1967 amendatory act shall become effective July 1, 1967." [1967 c 141 § 13.]

202

RCW 43.20B.415
State residential schools — Liability for costs of services — Limitation.

The estates of all mentally or physically deficient persons who have been admitted to the state residential schools listed in *RCW 72.33.030 either by application of their parents or guardian or by commitment of court, or who may hereafter be admitted or committed to such institutions, shall be liable for their per capita costs of care, support and treatment: PROVIDED, That the estate funds may not be reduced as a result of such liability below an amount as set forth in *RCW 72.33.180.

[1971 ex.s. c 118 § 2; 1967 c 141 § 2. Formerly RCW 72.33.655.]

Notes:

***Reviser's note:** RCW 72.33.030 and 72.33.180 were repealed by 1988 c 176 § 1007. See Title 71A RCW. The term "residential schools" was changed to "residential habilitation centers" by 1988 c 176.

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

203

RCW 43.20B.420
Residential habilitation centers — Determination of costs of services — Establishment of rates — Collection.

The charges for services as provided in RCW 43.20B.425 shall be based on the rates established for the purpose of receiving federal reimbursement for the same services. For those services for which there is no applicable federal reimbursement-related rate, charges shall be based on the average per capita costs, adjusted for inflation, of operating each of the residential habilitation centers for the previous reporting year taking into consideration all expenses of institutional operation, maintenance and repair, salaries and wages, equipment and supplies: PROVIDED, That all expenses directly related to the cost of education for persons under the age of twenty-two years shall be excluded from the computation of the average per capita cost. The department shall establish rates on a per capita basis and promulgate those rates or the methodology used in computing costs and establishing rates as rules of the department in accordance with chapter 34.05 RCW. The department shall be charged with the duty of collection of charges incurred under RCW 43.20B.410 through 43.20B.455, which may be enforced by civil action instituted by the attorney general within or without the state.

[1988 c 176 § 903; 1987 c 75 § 24; 1984 c 200 § 1; 1979 c 141 § 238; 1967 c 141 § 3. Formerly RCW 72.33.660.]

Notes:

Severability -- 1988 c 176: See RCW 71A.10.900.

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

204

RCW 43.20B.425
Residential habilitation centers — Costs of services — Investigation and determination of ability to pay — Exemptions.

The department shall investigate and determine the assets of the estates of each resident of a residential habilitation center and the ability of each such estate to pay all, or any portion of, the average monthly charge for care, support and treatment at a residential habilitation center as determined by the procedure set forth in RCW 43.20B.420: PROVIDED, That the sum as set forth in RCW 71A.20.100 shall be retained by the estate of the resident at all times for such personal needs as may arise: PROVIDED FURTHER, That where any person other than a resident or the guardian of the resident's estate deposits funds so that the depositor and a resident become joint tenants with the right of survivorship, such funds shall not be considered part of the resident's estate so long as the resident is not the sole survivor among such joint tenants.

[1988 c 176 § 904; 1987 c 75 § 25; 1971 ex.s. c 118 § 3; 1967 c 141 § 4. Formerly RCW 72.33.665.]

Notes:

Severability -- 1988 c 176: See RCW 71A.10.900.

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

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RCW 43.20B.430
Residential habilitation centers — Costs of services — Notice and finding of responsibility — Service — Adjudicative proceeding.

In all cases where a determination is made that the estate of a resident of a residential habilitation center is able to pay all or any portion of the charges, a notice and finding of responsibility shall be served on the guardian of the resident's estate, or if no guardian has been appointed then to the resident, the resident's spouse, or other person acting in a representative capacity and having property in his or her possession belonging to a resident. The notice shall set forth the amount the department has determined that such estate is able to pay, not to exceed the charge as fixed in accordance with RCW 43.20B.420, and the responsibility for payment to the department shall commence twenty-eight days after personal service of such notice and finding of responsibility. Service shall be in the manner prescribed for the service of a summons in a civil action or may be served by certified mail, return receipt requested. The return receipt signed by addressee only is prima facie evidence of service. An application for an adjudicative proceeding from the determination of responsibility may be made to the secretary by the guardian of the resident's estate, or if no guardian has been appointed then by the resident, the resident's spouse, or other person acting in a representative capacity and having property in his or her possession belonging to a resident of a state school, within such twenty-eight day period. The application must be written and served on the secretary by registered or certified mail, or by personal service. If no application is filed, the notice and finding of responsibility shall become final. If an application is filed, the execution of notice and finding of responsibility shall be stayed pending the final adjudicative order. The hearing shall be conducted in a local department office or other location in Washington convenient to the appellant. The proceeding is governed by the Administrative Procedure Act, chapter 34.05 RCW.

[1989 c 175 § 99; 1988 c 176 § 905; 1987 c 75 § 26; 1985 c 245 § 6; 1982 c 189 § 7; 1979 c 141 § 239; 1970 ex.s. c 75 § 1; 1967 c 141 § 5. Formerly RCW 72.33.670.]

Notes:

Effective date -- 1989 c 175: See note following RCW 34.05.010.

Severability -- 1988 c 176: See RCW 71A.10.900.

Savings -- 1985 c 245: See note following RCW 43.20B.340.

Effective date -- 1982 c 189: See note following RCW 34.12.020.

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

206

RCW 43.20B.435
State residential habilitation centers — Costs of services — Modification or vacation of finding of responsibility.

The secretary, upon application of the guardian of the estate of the resident, and after investigation, or upon investigation without application, may, if satisfied of the financial ability or inability of such person to make payments in accordance with the original finding of responsibility, modify or vacate such original finding of responsibility, and enter a new finding of responsibility. The secretary's determination to modify or vacate findings of responsibility shall be served and be appealable in the same manner and in accordance with the same procedure for appeals of original findings of responsibility.

[1979 c 141 § 240; 1967 c 141 § 7. Formerly RCW 72.33.680.]

Notes:

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

207

RCW 43.20B.440
Residential habilitation centers — Costs of services — Charges payable in advance.

The charges for care, support, maintenance and treatment of persons at residential habilitation centers as provided by RCW 43.20B.410 through 43.20B.455 shall be payable in advance on the first day of each and every month to the department.

[1988 c 176 § 906; 1987 c 75 § 27; 1979 c 141 § 241; 1967 c 141 § 8. Formerly RCW 72.33.685.]

Notes:

Severability -- 1988 c 176: See RCW 71A.10.900.

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

208

RCW 43.20B.445
Residential habilitation centers — Costs of services — Reimbursement from property subsequently acquired — Placement outside school — Liability after death of resident.

The provisions of RCW 43.20B.410 through 43.20B.455 shall not be construed to prohibit or prevent the department of social and health services from obtaining reimbursement from any person liable under RCW 43.20B.410 through 43.20B.455 for payment of the full amount of the accrued per capita cost from any property acquired by gift, devise or bequest subsequent to and regardless of the initial findings of responsibility under RCW 43.20B.430: PROVIDED, That the estate of any resident of a residential habilitation center shall not be liable for such reimbursement subsequent to termination of services for that resident at the residential habilitation center: PROVIDED FURTHER, That upon the death of any person while a resident in a residential habilitation center, the person's estate shall become liable to the same extent as the resident's liability on the date of death.

[1988 c 176 § 907; 1987 c 75 § 28; 1979 c 141 § 242; 1967 c 141 § 9. Formerly RCW 72.33.690.]

Notes:

Severability -- 1988 c 176: See RCW 71A.10.900.

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

209

RCW 43.20B.450
State residential habilitation centers — Costs of services — Liabilities created apply to care, support, and treatment after July 1, 1967.

The liabilities created by RCW 43.20B.410 through 43.20B.455 shall apply to the care, support and treatment occurring after July 1, 1967.

[1987 c 75 § 29; 1967 c 141 § 11. Formerly RCW 72.33.695.]

Notes:

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

210

RCW 43.20B.455
Residential habilitation centers — Costs of services — Discretionary allowance in resident's fund.

Notwithstanding any other provision of RCW 43.20B.410 through 43.20B.455, the secretary may, if in the secretary's discretion any resident of a residential habilitation center can be terminated from receiving services at the habilitation center more rapidly and assimilated into a community, keep an amount not exceeding five thousand dollars in the resident's fund for such resident and such resident shall not thereafter be liable thereon for per capita costs of care, support and treatment as provided for in RCW 43.20B.415.

[1988 c 176 § 908; 1987 c 75 § 30; 1979 c 141 § 243; 1967 c 141 § 12. Formerly RCW 72.33.700.]

Notes:

Severability -- 1988 c 176: See RCW 71A.10.900.

Effective date -- 1967 c 141: See note following RCW 43.20B.410.

211

RCW 43.20B.460
Guardianship fees and additional costs for incapacitated clients paying part of costs — Maximum amount — Rules.

The department of social and health services shall establish by rule the maximum amount of guardianship fees and additional compensation for administrative costs that may be allowed by the court as compensation for a guardian or limited guardian of an incapacitated person who is a department of social and health services client residing in a nursing facility or in a residential or home setting and is required by the department of social and health services to contribute a portion of their income towards the cost of residential or supportive services.

[1994 c 68 § 2.]

2/2

RCW 71A.20.100
Personal property of resident — Secretary as custodian — Limitations — Judicial proceedings to recover.

The secretary shall serve as custodian without compensation of personal property of a resident of a residential habilitation center that is located at the residential habilitation center, including moneys deposited with the secretary for the benefit of the resident. As custodian, the secretary shall have authority to disburse moneys from the resident's fund for the following purposes and subject to the following limitations:

(1) Subject to specific instructions by a donor of money to the secretary for the benefit of a resident, the secretary may disburse any of the funds belonging to a resident for such personal needs of the resident as the secretary may deem proper and necessary.

(2) The secretary may pay to the department as reimbursement for the costs of care, support, maintenance, treatment, hospitalization, medical care, and habilitation of a resident from the resident's fund when such fund exceeds a sum as established by rule of the department, to the extent of any notice and finding of financial responsibility served upon the secretary after such findings shall have become final. If the resident does not have a guardian, parent, spouse, or other person acting in a representative capacity, upon whom notice and findings of financial responsibility have been served, then the secretary shall not make payments to the department as provided in this subsection, until a guardian has been appointed by the court, and the time for the appeal of findings of financial responsibility as provided in RCW 43.20B.430 shall not commence to run until the appointment of such guardian and the service upon the guardian of notice and findings of financial responsibility.

(3) When services to a person are changed from a residential center to another setting, the secretary shall deliver to the person, or to the parent, guardian, or agency legally responsible for the person, all or such portion of the funds of which the secretary is custodian as defined in this section, or other property belonging to the person, as the secretary may deem necessary to the person's welfare, and the secretary may deliver to the person such additional property or funds belonging to the person as the secretary may from time to time deem proper, so long as the person continues to receive service under this title. When the resident no longer receives any services under this title, the secretary shall deliver to the person, or to the parent, person, or agency legally responsible for the person, all funds or other property belonging to the person remaining in the secretary's possession as custodian.

(4) All funds held by the secretary as custodian may be deposited in a single fund, the receipts and expenditures from the fund to be accurately accounted for by the secretary. All interest accruing from, or as a result of the deposit of such moneys in a single fund shall be credited to the personal accounts of the residents. All expenditures under this section shall be subject to the duty of accounting provided for in this section.

(5) The appointment of a guardian for the estate of a resident shall terminate the secretary's authority as custodian of any funds of the resident which may be subject to the control of the guardianship, upon receipt by the secretary of a certified copy of letters of guardianship. Upon the guardian's request, the secretary shall immediately forward to the guardian any funds subject to the control of the guardianship or other property of the resident remaining in the secretary's possession, together with a full and final accounting of all receipts and expenditures made.

(6) Upon receipt of a written request from the secretary stating that a designated individual is a resident of the residential habilitation center and that such resident has no legally appointed guardian of his or her estate, any person, bank, corporation, or agency having possession of any money, bank accounts, or choses in action owned by such resident, shall, if the amount does not exceed two hundred dollars, deliver the same to the secretary as custodian and mail written notice of the delivery to such resident at the residential habilitation center. The receipt by the secretary shall constitute full and complete acquittance for such payment and the person, bank, corporation, or agency making such payment shall not be liable to the resident or his or her legal representative. All funds so received by the secretary shall be duly deposited by the secretary as custodian in the resident's fund to the personal account of the resident. If any proceeding is brought in any court to recover property so delivered, the attorney general shall defend the lawsuit without cost to the person, bank, corporation, or agency that delivered the property to the secretary, and the state shall indemnify such person, bank, corporation, or agency against any judgment rendered as a result of such proceeding.

[1988 c 176 § 710.]

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388-835-0920 << 388-835-0925 >> 388-835-0930

WAC 388-835-0925

No agency filings affecting this section since 2003

What is the purpose of this section?

The purpose of this chapter is to regulate the costs of care of mentally/physically deficient persons.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0925, filed 4/20/01, effective 5/21/01.]

214

388-835-0925 << 388-835-0930 >> 388-835-0935

WAC 388-835-0930

No agency filings affecting this section since 2003

How is the payment for residential facilities set?

The department sets the payment for residential facilities by the methodology noted in chapter 388-835 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0930, filed 4/20/01, effective 5/21/01.]

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388-835-0930 << 388-835-0935 >> 388-835-0940

WAC 388-835-0935 No agency filings affecting this section since 2003

How much of a resident's income is exempt from paying their care?

Residents whose total resources are insufficient to pay the actual cost of care must be entitled to a monthly exemption from income in the amount of twenty-five dollars.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0935, filed 4/20/01, effective 5/21/01.]

216

388-835-0935 << 388-835-0940 >> 388-835-0945

WAC 388-835-0940 No agency filings affecting this section since 2003

What if the estate of a resident is able to pay all or a portion of their monthly cost?

(1) If DSHS finds that the estate of a resident is able to pay all or a portion of their monthly costs for care, support, and treatment, they must serve a written notice of finding of responsibility (NFR) on the:

(a) Guardian of the resident's estate; or

(b) If a guardian has not been appointed, resident's spouse or parent or other person acting in a representative capacity and in possession of the resident's property; and

(c) The superintendent of the state school.

(2) If a resident is an adult and is not under a legal disability, the department must personally serve the NFR on the resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0940, filed 4/20/01, effective 5/21/01.]

217

388-835-0940 << 388-835-0945 >> 388-835-0950

WAC 388-835-0945 No agency filings affecting this section since 2003

If a resident or guardian is served by DSHS with a NFR when is payment due?

If a resident or guardian is served by DSHS with an NFR, payment is due thirty days after receiving the notice.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0945, filed 4/20/01, effective 5/21/01.]

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388-835-0945 << 388-835-0950 >> 388-835-0955

WAC 388-835-0950 No agency filings affecting this section since 2003

May a resident or guardian request a hearing if they disagree with the NFR?

If a resident or guardian disagrees with the NFR, they have the right to ask for a hearing under chapter 34.05 RCW. They must file a written hearing request within thirty days of receipt with the secretary of DSHS, ATTN: Determination Officer, P.O. Box 9768, Olympia, WA 98504.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0950, filed 4/20/01, effective 5/21/01.]

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388-835-0950 << 388-835-0955 >> End of Chapter

WAC 388-835-0955
What information must be included in the request for a hearing?

No agency filings affecting this section since 2003

The request for hearing must include:

(1) A specific statement of the issues and law involved;

(2) The grounds for contesting the department decision; and

(3) A copy of the NFR being contested.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0955, filed 4/20/01, effective 5/21/01.]

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RCW 71A.20.140
Resident desiring to leave center — Authority to hold resident limited.

(1) If a resident of a residential habilitation center desires to leave the center and the secretary believes that departures may be harmful to the resident, the secretary may hold the resident at the residential habilitation center for a period not to exceed forty-eight hours in order to consult with the person's legal representative as provided in RCW 71A.10.070 as to the best interests of the resident.

(2) The secretary shall adopt rules to provide for the application of subsection (1) of this section in a manner that protects the constitutional rights of the resident.

(3) Neither the secretary nor any person taking action under this section shall be civilly or criminally liable for performing duties under this section if such duties were performed in good faith and without gross negligence.

[1988 c 176 § 714.]

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Chapter 388-79 WAC
Guardianship fees for clients of the department

Last Update: 7/28/03

WAC Sections

388-79-010
Purpose.

These rules implement RCW 11.92.180 and 43.20B.460 to the extent that those statutes require the department to establish by rule the maximum amount of guardianship fees and additional compensation for administrative costs that may be allowed by the court for a guardian or limited guardian of an incapacitated person who is a Medicaid client of the department and is thus required by federal law to contribute to the cost of the client's long-term care.

[Statutory Authority: RCW 11.92.180, 43.20B.460. 03-16-022, § 388-79-010, filed 7/28/03, effective 8/28/03; 98-10-055, § 388-79-010, filed 4/30/98, effective 5/31/98.]

388-79-020
Definitions.

"Administrative costs" or **"costs"** means necessary costs paid by the guardian including attorney fees.

"Client" means a person who is eligible for and is receiving Medicaid-funded long-term care.

"Guardianship fees" or **"fees"** means necessary fees charged by a guardian for services rendered on behalf of a client.

"Participation" means the amount the client pays from current monthly income toward the cost of the client's long-term care.

[Statutory Authority: RCW 11.92.180, 43.20B.460. 03-16-022, § 388-79-020, filed 7/28/03, effective 8/28/03; 98-10-055, § 388-79-020, filed 4/30/98, effective 5/31/98.]

388-79-030
Maximum fees and costs.

The superior court may allow guardianship fees and administrative costs in an amount set out in an order. For orders entered after June 15, 1998, where the order establishes or continues a legal guardianship for a department client, and requires a future review or accounting; then unless otherwise modified by the process described in WAC 388-79-040:

(1) The amount of guardianship fees shall not exceed one hundred seventy-five dollars per month;

(2) The amount of administrative costs directly related to establishing a guardianship for a department client shall not

exceed seven hundred dollars; and

(3) The amount of administrative costs shall not exceed a total of six hundred dollars during any three-year period.

[Statutory Authority: RCW 11.92.180, 43.20B.460. 03-16-022, § 388-79-030, filed 7/28/03, effective 8/28/03; 98-10-055, § 388-79-030, filed 4/30/98, effective 5/31/98.]

388-79-040
Procedure to revise award letter after June 15, 1998, but before September 1, 2003.

After June 15, 1998, but before September 1, 2003, where a department client is subject to a guardianship then the department shall be entitled to notice of proceedings as described in RCW 11.92.150.

(1) The notice shall be given to the appropriate regional administrator of the program serving the department client. A list of the regional administrators will be available upon request.

(2) If the fees and costs requested and established by the order are equal to or lower than the maximum amount set by this rule then the award letter or document setting the department's client's participation shall be adjusted to reflect that amount upon receipt by the department of the court order setting a monthly amount.

(3) Should fees and costs above those requested in WAC 388-79-030 be requested:

(a) The appropriate regional administrator will be given notice of the hearing as described in RCW 11.92.150, and provided with copies of all supporting documents filed with the court.

(b) Should the court determine after consideration of the facts, law and evidence of the case, that fees and costs higher than normally allowed in WAC 388-79-030 are just and reasonable and should be allowed then the award letter or document setting the department client's participation shall be adjusted to reflect that amount upon receipt by the department of the court order setting a monthly amount.

[Statutory Authority: RCW 11.92.180, 43.20B.460. 03-16-022, § 388-79-040, filed 7/28/03, effective 8/28/03; 98-10-055, § 388-79-040, filed 4/30/98, effective 5/31/98.]

388-79-050
Procedure for allowing fees and costs from client participation after September 1, 2003.

(1) After September 1, 2003, where a client is subject to a guardianship the department shall be entitled to notice of proceedings as described in RCW 11.92.150.

(2) The notice must be served to the department's regional administrator of the program that is providing services to the client. A list of the regional administrators will be furnished upon request.

(3) If the fees and costs requested and established by the order are equal to or less than the maximum amounts allowed under WAC 388-79-030, then the department will adjust the client's current participation to reflect the amounts allowed upon receipt by the department of the court order setting the monthly amounts.

(4) Should fees and costs in excess of the amounts allowed in WAC 388-79-030 be requested:

(a) At least ten days before filing the request with the court, the guardian must present the request in writing to the appropriate regional administrator to allow the department an opportunity to consider whether the request should be granted on an exceptional basis.

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(b) In considering a request for extraordinary fees or costs, the department must consider the following factors:

(i) The department's obligation under federal and state law to ensure that federal Medicaid funding is not jeopardized by noncompliance with federal regulations limiting deductions from the client's participation amount;

(ii) The usual and customary guardianship services for which the maximum fees and costs under WAC 388-79-030 must be deemed adequate for a Medicaid client, including but not limited to:

(A) Acting as a representative payee;

(B) Managing the client's financial affairs;

(C) Preserving and/or disposing of property;

(D) Making health care decisions;

(E) Visiting and/or maintaining contact with the client;

(F) Accessing public assistance programs on behalf of the client;

(G) Communicating with the client's service providers; and

(H) Preparing any reports or accountings required by the court.

(iii) Extraordinary services provided by the guardian, such as:

(A) Unusually complicated property transactions;

(B) Substantial interactions with adult protective services or criminal justice agencies;

(C) Extensive medical services setup needs and/or emergency hospitalizations; and

(D) Litigation other than litigating an award of guardianship fees or costs.

(c) Should the court determine after consideration of the facts and law that fees and costs in excess of the amounts allowed in WAC 388-79-030 are just and reasonable and should be allowed, then the department will adjust the client's current participation to reflect the amounts allowed upon receipt by the department of the court order setting the monthly amounts.

(5) In no event may a client's participation be prospectively or retrospectively reduced to pay fees and costs incurred before the effective date of the client's Medicaid eligibility; or during any subsequent time period when the client was not eligible for, or did not receive long-term care services; or after the client has died. There is no client participation towards DDD certified and contracted supported living services under chapter 388-820 WAC, so the department has no responsibility to reimburse the client for guardianship fees when those fees result in the client having insufficient income to pay their living expenses.

(6) If the court at a prior accounting has allowed the guardian to receive fees and costs from the client's monthly income in advance of services rendered by the guardian, and the client dies before the next accounting, the fees and costs allowed by the court at the final accounting may be less than, but may not exceed, the amounts advanced and paid to the guardian from the client's income.

(7) Guardians must furnish the regional administrator with complete packets to include all documents filed with the court and with formal notice clearly identifying the amount requested.

[Statutory Authority: RCW 11.92.180, 43.20B.460. 03-16-022, § 388-79-050, filed 7/28/03, effective 8/28/03.]

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RCW 74.09.270
Failure to maintain trust funds in separate account — Penalties.

(1) Any person having any patient trust funds in his possession, custody, or control, who, knowing that he is violating any statute, regulation, or agreement, deliberately fails to deposit, transfer, or maintain said funds in a separate, designated, trust bank account as required by such statute, regulation, or agreement shall be guilty of a gross misdemeanor and shall be punished by imprisonment for not more than one year in the county jail, or by a fine of not more than ten thousand dollars or as authorized by RCW 9A.20.030, or by both such fine and imprisonment.

(2) "Patient trust funds" are funds received by any health care facility which belong to patients and are required by any state or federal statute, regulation, or by agreement to be kept in a separate trust bank account for the benefit of such patients.

(3) This section shall not be construed to prevent a prosecution for theft.

[1979 ex.s. c 152 § 8.]

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RCW 74.09.260
Excessive charges, payments — Penalties.

Any person, including any corporation, that knowingly:

(1) Charges, for any service provided to a patient under any medical care plan authorized under this chapter, money or other consideration at a rate in excess of the rates established by the department of social and health services; or

(2) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under such plan, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient):

(a) As a precondition of admitting a patient to a hospital or nursing facility; or

(b) As a requirement for the patient's continued stay in such facility,

when the cost of the services provided therein to the patient is paid for, in whole or in part, under such plan, shall be guilty of a class C felony: PROVIDED, That the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

[1991 sp.s. c 8 § 7; 1979 ex.s. c 152 § 7.]

Notes:
Effective date -- 1991 sp.s. c 8: See note following RCW 18.51.050.

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RCW 11.92.180
Compensation and expenses of guardian or limited guardian — Attorney's fees — Department of social and health services clients paying part of costs — Rules.

A guardian or limited guardian shall be allowed such compensation for his or her services as guardian or limited guardian as the court shall deem just and reasonable. Guardians and limited guardians shall not be compensated at county or state expense. Additional compensation may be allowed for other administrative costs, including services of an attorney and for other services not provided by the guardian or limited guardian. Where a guardian or limited guardian is an attorney, the guardian or limited guardian shall separately account for time for which compensation is requested for services as a guardian or limited guardian as contrasted to time for which compensation for legal services provided to the guardianship is requested. In all cases, compensation of the guardian or limited guardian and his or her expenses including attorney's fees shall be fixed by the court and may be allowed at any annual or final accounting; but at any time during the administration of the estate, the guardian or limited guardian or his or her attorney may apply to the court for an allowance upon the compensation or necessary expenses of the guardian or limited guardian and for attorney's fees for services already performed. If the court finds that the guardian or limited guardian has failed to discharge his or her duties as such in any respect, it may deny the guardian any compensation whatsoever or may reduce the compensation which would otherwise be allowed. Where the incapacitated person is a department of social and health services client residing in a nursing facility or in a residential or home setting and is required by the department of social and health services to contribute a portion of their income towards the cost of residential or supportive services then the department shall be entitled to notice of proceedings as described in RCW 11.92.150. The amount of guardianship fees and additional compensation for administrative costs shall not exceed the amount allowed by the department of social and health services by rule.

[1995 c 297 § 8; 1994 c 68 § 1; 1991 c 289 § 12; 1990 c 122 § 36; 1975 1st ex.s. c 95 § 33; 1965 c 145 § 11.92.180. Prior: 1917 c 156 § 216; RRS § 1586; prior: Code 1881 § 1627; 1855 p 19 § 25.]

Notes:

Rules of court: SPR 98.12W.

Effective date -- 1990 c 122: See note following RCW 11.88.005.

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and the Managing Trustee, through the Fiscal Service of the Department of the Treasury, and prior to any action thereon by the General Accounting Office, shall make payment in accordance with the certification of the Commissioner of Social Security (except that in the case of (A) an individual who will have completed ten years of service creditable under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1974, (B) the wife or husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 USCS § 231a], and (D) any other person entitled to benefits under section 202 of this Act [42 USCS § 402] on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974 [45 USCS §§ 231–231t], at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974): Provided, That where a review of the Commissioner's decision is or may be sought under subsection (g) the Commissioner of Social Security may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Commissioner of Social Security.

(j) **Representative payees.** (1)(A) If the Commissioner of Social Security determines that the interest of any individual under this title [42 USCS §§ 401 et seq.] would be served thereby, certification of payment of such individual's benefit under this title [42 USCS §§ 401 et seq.] may be made, regardless of the legal competency or incompetency of the individual, either for direct payment to the individual, or for his or her use and benefit, to another individual, or an organization, with respect to whom the requirements of paragraph (2) have been met (hereinafter in this subsection referred to as the individual's "representative payee"). If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee has misused any individual's benefit paid to such representative payee pursuant to this subsection or section 1631(a)(2) [42 USCS § 1383(a)(2)], the Commissioner of Social Security shall promptly revoke certification for payment of benefits to such representative payee pursuant to this subsection and certify payment to an alternative representative payee or, if the interest of the individual under this title [42 USCS §§ 401 et seq.] would be served thereby, to the individual.

(B) In the case of an individual entitled to benefits based on disability, the payment of such benefits shall be made to a representative payee if the Commissioner of Social Security determines that such payment would serve the interest of the individual because the individual also has an alcoholism or drug addiction condition (as determined by the Commissioner) and the individual is incapable of managing such benefits.

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(2)(A) Any certification made under paragraph (1) for payment of benefits to an individual's representative payee shall be made on the basis of—

(i) an investigation by the Commissioner of Social Security of the person to serve as representative payee, which shall be conducted in advance of such certification and shall, to the extent practicable, include a face-to-face interview with such person, and

(ii) adequate evidence that such certification is in the interest of such individual (as determined by the Commissioner of Social Security in regulations).

(B)(i) As part of the investigation referred to in subparagraph (A)(i), the Commissioner of Social Security shall—

(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity has been submitted with an application for benefits under this title or title XVI [42 USCS §§ 401 et seq. or 1381 et seq.],

(II) verify such person's social security account number (or employer identification number),

(III) determine whether such person has been convicted of a violation of section 208 or 1632 [42 USCS § 408 or 1383a], and

(IV) determine whether certification of payment of benefits to such person has been revoked pursuant to this subsection or payment of benefits to such person has been terminated pursuant to section 1631(a)(2)(A)(iii) [42 USCS § 1383(a)(2)(A)(iii)] by reason of misuse of funds paid as benefits under this title or title XVI [42 USCS §§ 401 et seq. or 1381 et seq.].

(ii) The Commissioner of Social Security shall establish and maintain a centralized file, which shall be updated periodically and which shall be in a form which renders it readily retrievable by each servicing office of the Social Security Administration. Such file shall consist of—

(I) a list of the names and social security account numbers (or employer identification numbers) of all persons with respect to whom certification of payment of benefits has been revoked on or after January 1, 1991, pursuant to this subsection, or with respect to whom payment of benefits has been terminated on or after such date pursuant to section 1631(a)(2)(A)(iii) [42 USCS § 1383(a)(2)(A)(iii)], by reason of misuse of funds paid as benefits under this title or title XVI [42 USCS §§ 401 et seq. or 1381 et seq.], and

(II) a list of the names and social security account numbers (or employer identification numbers) of all persons who have been convicted of a violation of section 208 or 1632 [42 USCS § 408 or 1383a].

(C)(i) Benefits of an individual may not be certified for payment to any other person pursuant to this subsection if—

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(I) such person has previously been convicted as described in subparagraph (B)(i)(III),

(II) except as provided in clause (ii), certification of payment of bene fits to such person under this subsection has previously been revoked as described in subparagraph (B)(i)(IV), or payment of benefits to such person pursuant to section 1631(a)(2)(A)(ii) [42 USCS § 1383(a)(2)(A)(ii)] has previously been terminated as described in section 1631(a)(2)(B)(ii)(IV) [42 USCS § 1383(a)(2)(B)(ii)(IV)], or

(III) except as provided in clause (iii), such person is a creditor of such individual who provides such individual with goods or services for consideration.

(ii) The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant exemptions to any person from the provisions of clause (i)(II) on a case-by-case basis if such exemption is in the best interest of the individual whose benefits would be paid to such person pursuant to this subsection.

(iii) Clause (i)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

(I) a relative of such individual if such relative resides in the same household as such individual,

(II) a legal guardian or legal representative of such individual,

(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State,

(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the certification of payment to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom such certification of payment would serve the best interests of such individual, or

(V) an individual who is determined by the Commissioner of Social Security, on the basis of written findings and under procedures which the Commissioner of Social Security shall prescribe by regulation, to be acceptable to serve as a representative payee.

(iv) The procedures referred to in clause (iii)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Commissioner of Social Security, that—

(I) such individual poses no risk to the beneficiary,

(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest, and

(III) no other more suitable representative payee can be found.

(v) In the case of an individual described in paragraph (1)(B), when selecting such individual's representative payee, preference shall be given to—

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(I) a community-based nonprofit social service agency licensed or bonded by the State,

(II) a Federal, State, or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities,

(III) a State or local government agency with fiduciary responsibilities, or

(IV) a designee of an agency (other than of a Federal agency) referred to in the preceding subclauses of this clause, if the Commissioner of Social Security deems it appropriate,

unless the Commissioner of Social Security determines that selection of a family member would be appropriate.

(D)(i) Subject to clause (ii), if the Commissioner of Social Security makes a determination described in the first sentence of paragraph (1) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Commissioner of Social Security may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subsection.

(ii)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (i) shall be for a period of not more than 1 month.

(II) Subclause (I) shall not apply in any case in which the individual is, as of the date of the Commissioner's determination, legally incompetent, under the age of 15 years, or described in paragraph (1)(B).

(iii) Payment pursuant to this subsection of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual or the representative payee as a single sum or over such period of time as the Commissioner of Social Security determines is in the best interest of the individual entitled to such benefits.

(E)(i) Any individual who is dissatisfied with a determination by the Commissioner of Social Security to certify payment of such individual's benefit to a representative payee under paragraph (1) or with the designation of a particular person to serve as representative payee shall be entitled to a hearing by the Commissioner of Social Security to the same extent as is provided in subsection (b), and to judicial review of the Commissioner's final decision as is provided in subsection (g).

(ii) In advance of the certification of payment of an individual's benefit to a representative payee under paragraph (1), the Commissioner of Social Security shall provide written notice of the Commissioner's

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initial determination to certify such payment. Such notice shall be provided to such individual, except that, if such individual—

(I) is under the age of 15,

(II) is an unemancipated minor under the age of 18, or

(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

(iii) Any notice described in clause (ii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (i) of such individual or of such individual's legal guardian or legal representative—

(I) to appeal a determination that a representative payee is necessary for such individual,

(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

(III) to review the evidence upon which such designation is based and submit additional evidence.

(3)(A) In any case where payment under this title [42 USCS §§ 401 et seq.] is made to a person other than the individual entitled to such payment, the Commissioner of Social Security shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Commissioner of Social Security shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(B) Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a State institution. In such cases, the Commissioner of Social Security shall establish a system of accountability monitoring for institutions in each State.

(C) Subparagraph (A) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the other person to whom such payment is made is the institution.

(D) Notwithstanding subparagraphs (A), (B), and (C), the Commissioner of Social Security may require a report at any time from any person receiving payments on behalf of another, if the Commissioner of Social Security has reason to believe that the person receiving such payments is misusing such payments.

(E) The Commissioner of Social Security shall maintain a centralized file, which shall be updated periodically and which shall be in a form which will be readily retrievable by each servicing office of the Social Security Administration, of—

(i) the address and the social security account number (or employer identification number) of each representative payee who is receiving benefit payments pursuant to this subsection or section 1631(a)(2) [42 USCS § 1383(a)(2)], and

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(ii) the address and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this subsection or section 1631(a)(2) |42 USCS § 1383(a)(2)|.

(F) Each servicing office of the Administration shall maintain a list, which shall be updated periodically, of public agencies and community-based nonprofit social service agencies which are qualified to serve as representative payees pursuant to this subsection or section 1631(a)(2) |42 USCS § 1383(a)(2)| and which are located in the area served by such servicing office.

(4)(A)(i) A qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to this subsection if such fee does not exceed the lesser of—

(I) 10 percent of the monthly benefit involved, or

(II) $25.00 per month ($50.00 per month in any case in which the individual is described in paragraph (1)(B)).

The Commissioner of Social Security shall adjust annually (after 1995) each dollar amount set forth in subclause (II) under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A) |42 USCS § 415(i)(2)(A)|, except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00.

(ii) In the case of an individual who is no longer currently entitled to monthly insurance benefits under this title |42 USCS §§ 401 et seq.| but to whom all past-due benefits have not been paid, for purposes of clause (i), any amount of such past-due benefits payable in any month shall be treated as a monthly benefit referred to in clause (i)(I).

Any agreement providing for a fee in excess of the amount permitted under this subparagraph shall be void and shall be treated as misuse by such organization of such individual's benefits.

(B) For purposes of this paragraph, the term "qualified organization" means any State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any community-based nonprofit social service agency which is bonded or licensed in each State in which it serves as a representative payee, if such agency, in accordance with any applicable regulations of the Commissioner of Social Security—

(i) regularly provides services as the representative payee, pursuant to this subsection or section 1631(a)(2) |42 USCS § 1383(a)(2)|, concurrently to 5 or more individuals, |and|

(ii) demonstrates to the satisfaction of the Commissioner of Social

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Security that such agency is not otherwise a creditor of any such individual.

The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exception from clause (ii) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(C) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under subparagraph (A) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

(5) In cases where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to such misused benefits. The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(6) The Commissioner of Social Security shall include as a part of the annual report required under section 704 [42 USCS § 904] information with respect to the implementation of the preceding provisions of this subsection, including the number of cases in which the representative payee was changed, the number of cases discovered where there has been a misuse of funds, how any such cases were dealt with by the Commissioner of Social Security, the final disposition of such cases, including any criminal penalties imposed, and such other information as the Commissioner of Social Security determines to be appropriate.

(7) For purposes of this subsection, the term "benefit based on disability" of an individual means a disability insurance benefit of such individual under section 223 [42 USCS § 423] or a child's, widow's, or widower's insurance benefit of such individual under section 202 [42 USCS § 402] based on such individual's disability.

(k) Payments to incompetents. Any payment made after December 31, 1939, under conditions set forth in subsection (j) any payment made before January 1, 1940, to, or on behalf of, a legally incompetent individual, and any payment made after December 31, 1939, to a legally incompetent individual without knowledge by the Commissioner of Social Security of incompetency prior to certification of payment, if otherwise valid under this title [42 USCS §§ 401 et seq.], shall be a complete settlement and satisfaction of any claim, right, or interest in and to such payment.

(l) Delegation of powers and duties by Commissioner of Social Security. The Commissioner of Social Security is authorized to delegate to any member, officer, or employee of the Social Security Administration designated by the Commissioner any of the powers conferred upon the Commissioner by this section, and is authorized to be represented by the Commissioner's own at-

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pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) hereof which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) hereof, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

(h) [Unchanged]

(i) Certification for payment. Upon final decision of the Commissioner of Social Security, or upon final judgment of any court of competent jurisdiction, that any person is entitled to any payment or payments under this title [42 USCS §§ 401 et seq.], the Commissioner of Social Security shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Department of the Treasury, and prior to any action thereon by the General Accounting Office [Government Accountability Office], shall make payment in accordance with the certification of the Commissioner of Social Security (except that in the case of (A) an individual who will have completed ten years of service (or five or more years of service, all of which accrues after December 31, 1995) creditable under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1974, (B) the wife or husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974 [45 USCS § 231a], and (D) any other person entitled to benefits under section 202 of this Act [42 USCS § 402] on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974 [45 USCS §§ 231 et seq.], at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974): *Provided,* That where a review of the Commissioner's decision is or may be sought under subsection (g) the Commissioner of Social Security may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Commissioner of Social Security.

(j) Representative payees. (1)(A) If the Commissioner of Social Security determines that the interest of any individual under this title [42 USCS §§ 401 et seq.] would be served thereby, certification of payment of such individual's benefit under this title [42 USCS §§ 401 et seq.] may be made, regardless of the legal competency or incompetency of the individual, either for direct payment to the individual, or for his or her use and benefit, to another individual, or an organization, with respect to whom the requirements of paragraph (2) have been met (hereinafter in this subsection referred to as the individual's "representative payee"). If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee has misused any individual's benefit paid to such representative payee pursuant to this subsection or section 807 or 1631(a)(2) [42 USCS § 1007 or 1383(a)(2)], the Commissioner of Social Security shall promptly revoke certification for payment of benefits to such representative payee pursuant to this subsection and certify payment to an alternative representative payee or, if the interest of the individual under this title [42 USCS §§ 401 et seq.] would be served thereby, to the individual.

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(B) [Unchanged]

(2)(A) [Unchanged]

(B)(i) As part of the investigation referred to in subparagraph (A)(i), the Commissioner of Social Security shall—

(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity has been submitted with an application for benefits under this title, title VIII, or title XVI [42 USCS §§ 401 et seq., 1001 et seq. or 1381 et seq.],

(II) [Unchanged]

(III) determine whether such person has been convicted of a violation of section 208, 811, or 1632 [42 USCS § 408, 1011, or 1383a],

(IV) obtain information concerning whether such person has been convicted of any other offense under Federal or State law which resulted in imprisonment for more than 1 year,

(V) obtain information concerning whether such person is a person described in section 202(x)(1)(A)(iv) [42 USCS § 402(x)(1)(A)(iv)], and

(VI) determine whether certification of payment of benefits to such person has been revoked pursuant to this subsection, the designation of such person as a representative payee has been revoked pursuant to section 807(a) [42 USCS § 1007(a)], or payment of benefits to such person has been terminated pursuant to section 1631(a)(2)(A)(iii) [42 USCS § 1383(a)(2)(A)(iii)] by reason of misuse of funds paid as benefits under this title, title VIII, or title XVI [42 USCS §§ 401 et seq., 1001 et seq. or 1381 et seq.].

(ii) The Commissioner of Social Security shall establish and maintain a centralized file, which shall be updated periodically and which shall be in a form which renders it readily retrievable by each servicing office of the Social Security Administration. Such file shall consist of—

(I) a list of the names and social security account numbers (or employer identification numbers) of all persons with respect to whom certification of payment of benefits has been revoked on or after January 1, 1991, pursuant to this subsection, whose designation as a representative payee has been revoked pursuant to section 807(a) [42 USCS § 1007(a)], or with respect to whom payment of benefits has been terminated on or after such date pursuant to section 1631(a)(2)(A)(iii) [42 USCS § 1383(a)(2)(A)(iii)], by reason of misuse of funds paid as benefits under this title, title VIII, or title XVI [42 USCS §§ 401 et seq., 1001 et seq., or 1381 et seq.], and

(II) a list of the names and social security account numbers (or employer identification numbers) of all persons who have been convicted of a violation of section 208, 811, or 1632 [42 USCS § 408, 1011 or 1383a].

(iii) Notwithstanding the provisions of section 552a of title 5, United States Code [5 USCS § 552a], or any other provision of Federal or State law (other than section 6103 of the Internal Revenue Code of 1986 [26 USCS § 6103] and section 1106(c) of this Act [42 USCS § 1306(c)]), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, social security account number, and photograph (if applicable) of any person investigated under this paragraph, if the officer furnishes the Commissioner with the name of such person and such other identifying information as may reasonably be required by the Commissioner to establish the unique identity of such person, and notifies the Commissioner that—

(I) such person is described in section 202(x)(1)(A)(iv) [42 USCS § 402(x)(1)(A)(iv)],

(II) such person has information that is necessary for the officer to conduct the officer's official duties, and

(III) the location or apprehension of such person is within the officer's official duties.

(C)(i) Benefits of an individual may not be certified for payment to any other person pursuant to this subsection if—

(I) [Unchanged]

(II) except as provided in clause (ii), certification of payment of benefits to such person under this subsection has previously been revoked as described in subparagraph (B)(i)(VI) the designation of such person as a representative payee has been revoked pursuant to section 807(a) [42 USCS § 1007(a)], or payment of benefits to such person pursuant to section 1631(a)(2)(A)(ii) [42 USCS § 1383(a)(2)(A)(ii)] has previously been terminated as described in section 1631(a)(2)(B)(ii)(VI) [42 USCS § 1383(a)(2)(B)(ii)(VI)],

(III) except as provided in clause (iii), such person is a creditor of such individual who provides such individual with goods or services for consideration,

(IV) such person has previously been convicted as described in subparagraph (B)(i)(IV), unless the Commissioner determines that such certification would be appropriate notwithstanding such conviction, or

(V) such person is a person described in section 202(x)(1)(A)(iv) [42 USCS § 402(x)(1)(A)(iv)].

(ii)–(iv) [Unchanged]

(v) In the case of an individual described in paragraph (1)(B), when selecting such individual's representative payee, preference shall be given to—

(I) a certified community-based nonprofit social service agency (as defined in paragraph (10)),

(II)–(IV) [Unchanged]

unless the Commissioner of Social Security determines that selection of a family member would be appropriate.

(D), (E) [Unchanged]

(3)(A)–(D) [Unchanged]

(E) In any case in which the person described in subparagraph (A) or (D) receiving payments on behalf of another fails to submit a report required by the Commissioner of Social Security under subparagraph (A) or (D), the Commissioner may, after furnishing notice to such person and the individual entitled to such payment, require that such person appear in person at a field office of the Social Security Administration serving the area in which the individual resides in order to receive such payments.

(F) The Commissioner of Social Security shall maintain a centralized file, which shall be updated periodically and which shall be in a form which will be readily retrievable by each servicing office of the Social Security Administration, of—

(i) the address and the social security account number (or employer identification number) of each representative payee who is receiving benefit payments pursuant to this subsection, section 807 [42 USCS § 1007], or section 1631(a)(2) [42 USCS § 1383(a)(2)], and

(ii) the address and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this subsection, section 807 [42 USCS § 1007], or section 1631(a)(2) [42 USCS § 1383(a)(2)].

(G) Each servicing office of the Administration shall maintain a list, which shall be updated periodically, of public agencies and certified community-based nonprofit social service agencies (as defined in paragraph (10)) which are qualified to serve as representative payees pursuant to this subsection or section 807 or 1631(a)(2) [42 USCS § 1007 or 1383(a)(2)] and which are located in the area served by such servicing office.

(4)(A)(i) Except as provided in the next sentence, a qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to this subsection if such fee does not exceed the lesser of—

(I), (II) [Unchanged]

A qualified organization may not collect a fee from an individual for any month with respect to which the Commissioner of Social Security or a court of competent jurisdiction has determined that the organization misused all or part of the individual's benefit, and any amount so collected by the qualified organization for such month shall be treated as a misused part of the individual's benefit for purposes of paragraphs (5) and (6). The Commissioner of Social Security shall adjust annually (after 1995) each dollar amount set forth in subclause (II) under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A) [42 USCS § 415(i)(2)(A)], except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00.

(ii) [Unchanged]

Any agreement providing for a fee in excess of the amount permitted under this subparagraph shall be void and shall be treated as misuse by such organization of such individual's benefits.

(B) For purposes of this paragraph, the term "qualified organization" means any State or local government agency whose mission is to carry out income maintenance, social service, or health care-related activities, any State or local government agency with fiduciary responsibilities, or any certified community-based nonprofit social service agency (as defined in paragraph (10)), if such agency, in accordance with any applicable regulations of the Commissioner of Social Security—

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(i) regularly provides services as the representative payee, pursuant to this subsection or section 807 or 1631(a)(2) [42 USCS § 1007 or 1383(a)(2)], concurrently to 5 or more individuals, [and]

(ii) [Unchanged]

The Commissioner of Social Security shall prescribe regulations under which the Commissioner of Social Security may grant an exception from clause (ii) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(C) [Unchanged]

(5) In cases where the negligent failure of the Commissioner of Social Security to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to such misused benefits. In any case in which a representative payee that—

(A) is not an individual (regardless of whether it is a "qualified organization" within the meaning of paragraph (4)(B)); or

(B) is an individual who, for any month during a period when misuse occurs, serves 15 or more individuals who are beneficiaries under this title [42 USCS §§ 401 et seq.], title VIII [42 USCS §§ 1001 et seq.], title XVI [42 USCS §§ 1381 et seq.], or any combination of such titles;

misuses all or part of an individual's benefit paid to such representative payee, the Commissioner of Social Security shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to the amount of such benefit so misused. The provisions of this paragraph are subject to the limitations of paragraph (7)(B). The Commissioner of Social Security shall make a good faith effort to obtain restitution from the terminated representative payee.

(6)(A) In addition to such other reviews of representative payees as the Commissioner of Social Security may otherwise conduct, the Commissioner shall provide for the periodic onsite review of any person or agency located in the United States that receives the benefits payable under this title [42 USCS §§ 401 et seq.] (alone or in combination with benefits payable under title VIII [42 USCS §§ 1001 et seq.] or title XVI [42 USCS §§ 1381 et seq.]) to another individual pursuant to the appointment of such person or agency as a representative payee under this subsection, section 807 [42 USCS § 1007], or section 1631(a)(2) [42 USCS § 1383(a)(2)] in any case in which—

(i) the representative payee is a person who serves in that capacity with respect to 15 or more such individuals;

(ii) the representative payee is a certified community-based nonprofit social service agency (as defined in paragraph (10) of this subsection or section 1631(a)(2)(I) [42 USCS § 1383(a)(2)(I)]); or

(iii) the representative payee is an agency (other than an agency described in clause (ii)) that serves in that capacity with respect to 50 or more such individuals.

(B) Within 120 days after the end of each fiscal year, the Commissioner shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the results of periodic onsite reviews conducted during the fiscal year pursuant to subparagraph (A) and of any other reviews of representative payees conducted during such fiscal year in connection with benefits under this title [42 USCS §§ 401 et seq.]. Each such report shall describe in detail all problems identified in such reviews and any corrective action taken or planned to be taken to correct such problems, and shall include—

(i) the number of such reviews;

(ii) the results of such reviews;

(iii) the number of cases in which the representative payee was changed and why;

(iv) the number of cases involving the exercise of expedited, targeted oversight of the representative payee by the Commissioner conducted upon receipt of an allegation of misuse of funds, failure to pay a vendor, or a similar irregularity;

(v) the number of cases discovered in which there was a misuse of funds;

(vi) how any such cases of misuse of funds were dealt with by the Commissioner;

(vii) the final disposition of such cases of misuse of funds, including any criminal penalties imposed; and

(viii) such other information as the Commissioner deems appropriate.

(7)(A) If the Commissioner of Social Security or a court of competent jurisdiction determines that a representative payee that is not a Federal, State, or local government agency has misused all or part of an individual's benefit that was paid to such representative payee under this subsection, the representative payee shall be liable for the amount misused, and

such amount (to the extent not repaid by the representative payee) shall be treated as an overpayment of benefits under this title [42 USCS §§ 401 et seq.] to the representative payee for all purposes of this Act [42 USCS §§ 301 et seq.] and related laws pertaining to the recovery of such overpayments. Subject to subparagraph (B), upon recovering all or any part of such amount, the Commissioner shall certify an amount equal to the recovered amount for payment to such individual or such individual's alternative representative payee.

(B) The total of the amount certified for payment to such individual or such individual's alternative representative payee under subparagraph (A) and the amount certified for payment under paragraph (5) may not exceed the total benefit amount misused by the representative payee with respect to such individual.

(8) For purposes of this subsection, the term "benefit based on disability" of an individual means a disability insurance benefit of such individual under section 223 [42 USCS § 423] or a child's, widow's, or widower's insurance benefit of such individual under section 202 [42 USCS § 402] based on such individual's disability.

(9) For purposes of this subsection, misuse of benefits by a representative payee occurs in any case in which the representative payee receives payment under this title [42 USCS §§ 401 et seq.] for the use and benefit of another person and converts such payment, or any part thereof, to a use other than for the use and benefit of such other person. The Commissioner of Social Security may prescribe by regulation the meaning of the term "use and benefit" for purposes of this paragraph.

(10) For purposes of this subsection, the term "certified community-based nonprofit social service agency" means a community-based nonprofit social service agency which is in compliance with requirements, under regulations which shall be prescribed by the Commissioner, for annual certification to the Commissioner that it is bonded in accordance with requirements specified by the Commissioner and that it is licensed in each State in which it serves as a representative payee (if licensing is available in the State) in accordance with requirements specified by the Commissioner. Any such annual certification shall include a copy of any independent audit on the agency which may have been performed since the previous certification.

(k)–(o) [Unchanged]

(p) Special rules in case of Federal service. (1), (2) [Unchanged]

(3) The provisions of paragraphs (1) and (2) shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of paragraphs (1) and (2) the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of paragraphs (1) and (2) shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Homeland Security, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of paragraphs (1) and (2) the Secretary of Homeland Security shall be deemed to be the head of such instrumentality.

(q) [Unchanged]

(r) Use of death certificates to correct program information. (1)–(7) [Unchanged]

(8)(A) The Commissioner of Social Security shall, upon the request of the official responsible for a State driver's license agency pursuant to the Help America Vote Act of 2002—

(i) enter into an agreement with such official for the purpose of verifying applicable information, so long as the requirements of subparagraphs (A) and (B) of paragraph (3) are met; and

(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any applicable information disclosed and procedures to permit such agency to use the applicable information for the purpose of maintaining its records.

(B) Information provided pursuant to an agreement under this paragraph shall be provided at such time, in such place, and in such manner as the Commissioner determines appropriate.

(C) The Commissioner shall develop methods to verify the accuracy of information provided by the agency with respect to applications for voter registration, for whom the last 4 digits of a social security number are provided instead of a driver's license number.

(D) For purposes of this paragraph—

(i) the term "applicable information" means information regarding whether—

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ney's fees under Equal Access to Justice Act. Burr v Bowen (1992, ND Ill) 782 F Supp 1285, 36 Soc Sec Rep Serv 324, CCH Unemployment Ins Rep ¶ 16474A.

Automatic remand under Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460, 98 Stat. 1794) is not final judgment for EAJA purposes. Mendez v Sullivan (1992, ED Pa) 792 F Supp 375, 38 Soc Sec Rep Serv 3, CCH Unemployment Ins Rep ¶ 16951.

Remand that was proposed by Secretary, prior to filing of his answer and copy of transcript, for further consideration of claimant's non-exertional impairments, further development of record, including consultative examinations, and for taking new testimony from vocational expert, was sentence six (42 USCS § 405(g)) remand, even though remand order did not specify finding of good cause relative to taking of new evidence; thus, remand order was not final judgment for purpose of EAJA fees. Longey v Sullivan (1993, DC Vt) 812 F Supp 453, 40 Soc Sec Rep Serv 165.

Claimant's application for award of EAJA attorney's fees was timely filed on May 22, 1992, even though parties had stipulated to remand case to Secretary for further proceedings, and that stipulation, so ordered by court, had been filed by clerk on July 31, 1991, because court never entered judgment following its remand order; thus, court never issued final judgment in case. Flanders v Shalala (1994, ND NY) 1994 US Dist LEXIS 9189.

Minute order filed by District Court, which indicated that claimant's motion for summary judgment was granted, that Secretary's motion for summary judgment was denied, and that case was remanded for full and fair hearing before ALJ, did not constitute final judgment under FRCP 58, because none of court's entries stated that decision was final order that disposed of case in its entirety; therefore, claimant's application for award of EAJA attorney's fees, filed more than year after entry of minute order, was timely. Lopez v Shalala (1994, ND Ill) 1994 US Dist LEXIS 12247.

§ 407. Assignment; amendment of section

(a) The right of any person to any future payment under this title [42 USCS §§ 401 et seq.] shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this title [42 USCS §§ 401 et seq.] shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

(b) No other provision of law, enacted before, on, or after the date of the enactment of this section [enacted April 20, 1983], may be construed to limit, supersede, or otherwise modify the provisions of this section except to the extent that it does so by express reference to this section.

(Aug. 14, 1935, ch 531, Title II, § 207, 49 Stat. 624; Aug. 10, 1939, ch 666, Title II, § 201, 53 Stat. 1372; April 20, 1983, P. L. 98-21, Title III, Part C, § 335(a), 97 Stat. 130.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

Explanatory notes:

Prior to amendment by Act Aug. 10, 1939, the provisions of this section appeared as § 208 of Act Aug. 14, 1935. The former provisions of § 207 of Act Aug. 14, 1935 now appear as 42 USCS § 405(i).

Effective date of section:

Act Aug. 10, 1939, ch 666, Title II, § 201, 53 Stat. 1362, provided that this section is effective Jan. 1, 1940.

Amendments:

1939. Act Aug. 10, 1939 (effective 1/1/40 as provided by § 201 of such Act) substituted this section for one which read: "The Board shall from time to time certify to the Secretary of the Treasury the name and address of each person entitled to receive a payment under this title, the

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social security attorney who achieved exceptional results for his client. Droke v Barnhart (2005, WD Tenn) 106 Soc Sec Rep Serv 135.

In granting request for attorneys fees of 25 percent of claimant's award pursuant to 42 USCS § 406(b)(1), court found that claimant's contingency fee contract was reasonable in light of attorneys' skill and experience, court refused to penalize attorneys for representing their client more efficiently than less experienced counsel may have, court considered Social Security lawyer's risk of loss, and court concluded that 25 percent fee award was reasonable. Faircloth v Barnhart (2005, DC NM) 398 F Supp 2d 1169.

Court allowed award of attorney's fees for 25 percent of past due award amount, pursuant to contingency fee agreement entered into between attorney and claimant, even if actual hourly amount appeared excessive, because attorney had considerable experience in area of Social Security law, proceeded with claimant's case for over three years, bore risk that there would be no fee if there were no recovery, and optimized result for claimant. Thomas v Barnhart (2005, MD Ala) 412 F Supp 2d 1240.

Motion for attorney's fees pursuant to 42 USCS § 406(b)(1) was granted where (1) contingency-fee agreement between parties and amount of requested fee under that agreement were reasonable, (2) claimant's attorney was entitled to requested fee, amount equal to twenty-five percent of claimant's past-due benefits, (3) character of representation, attorney's expertise in Social Security law, result achieved, and absence of any delay in proceedings by attorney, all supported reasonableness of fee award, (4) court also considered deference owed to agreement between attorney and client, interest in assuring that attorneys continued to represent disability claimants, and lack of any factor indicating that requested award would have resulted in windfall to attorney, and (5) Commissioner of Social Security acknowledged that it made error by failing to withhold entire attorney's fee award from claimant's past-due benefits. Silliman v Barnhart (2006, WD NY) 421 F Supp 2d 625.

Since court found that contingency-fee agreement, awarding attorney 25 percent of past due benefits, between successful claimant for Social Security benefits and her attorney and amount of requested fee under that agreement were reasonable, claimant's 42 USCS § 406(b)(1) motion for attorney's fees was granted. Colegrove v Barnhart (2006, WD NY) 435 F Supp 2d 218.

76. Particular awards under Equal Access to Justice Act

In social security case, plaintiff's petition for award of attorney's fees under Equal Access to Justice Act, 28 USCS § 2412, was granted in amount that was requested where: (1) prevailing market rate for representation in social security cases was greater than statutory amount of $125, after adjustment of inflation, and (2) adjusted hourly rate requested, which was about $148 per hour, did not exceed prevailing market rate for similar services that were provided by attorneys of reasonably comparable skills, experience, and reputation, and adjustment based upon Consumer Price Index was appropriate. Ballard v Barnhart (2004, ND Ala) 329 F Supp 2d 1278, 99 Soc Sec Rep Serv 530.

77. Miscellaneous

As an aid to assessing whether fee award based on contingent-fee agreement is reasonable for purposes of 42 USCS § 406(b), court may require claimant's attorney to submit a record of hours spent representing claimant and a statement of attorney's normal hourly billing charge for noncontingent-fee cases. Gisbrecht v Barnhart (2002) 535 US 789, 152 L Ed 2d 996, 122 S Ct 1817, 80 Soc Sec Rep Serv 309, 2002 CDOS 4543, 2002 Daily Journal DAR 5795, CCH Unemployment Ins Rep ¶ 16729B, 15 FLW Fed S 314, on remand, remanded (2002, CA9) 300 F3d 1158, 2002 CDOS 7800, 2002 Daily Journal DAR 9793, vacated, reconsideration gr (2002, CA9) 305 F3d 1256, 2002 CDOS 9834, 2002 Daily Journal DAR 11030.

IV. PROCEDURAL MATTERS

78. Notice

In applying 14-day limitation found in Fed. R. Civ. P. 54(d) and M.D. Fla. Gen. R. 4.18(a) to 42 USCS § 406(b), period should begin to run from day that award notice is issued. Bergen v Comm'r of Soc. Sec. (2006, CA11 Fla) 444 F3d 1281.

80. Filing requirements for fees under EAJA

Social Security's determination that disability benefits claimant was able to perform light work was reversed as hypothetical to vocational expert failed to consider her limitations in record, including unrefuted complaints of pain; counsel was granted extension of time to petition for attorney's fees. Webster v Barnhart (2004, ND Ala) 343 F Supp 2d 1085.

81. —When 30-day limitation period begins to run

In suit in which court determined that minor child was entitled to Supplemental Security Income after child's request for benefits was denied by Commissioner of Social Security Administration, court granted child's attorney 30 days in which to file petition for attorney's fees under 42 USCS 406(b), but attorney was warned that court's order did not extend time limits for filing motion for attorney's fees under Equal Access to Justice Act. Stanton v Astrue (2007, ND Ala) 482 F Supp 2d 1318.

87. Review of fee award

Statutory and regulatory scheme governing payment of fees to representatives of social security claimants does not violate equal protection because it draws certain distinctions between attorneys and nonattorneys. Cordoba v Massanari (2001, CA10 NM) 256 F3d 1044, 74 Soc Sec Rep Serv 376, CCH Unemployment Ins Rep ¶ 16658B, 2001 Colo J C A R 3808, cert den (2002) 534 US 1131, 151 L Ed 2d 974, 122 S Ct 1071.

§ 407. Assignment; amendment of section

(a), (b) [Unchanged]

(c) Nothing in this section shall be construed to prohibit withholding taxes from any benefit under this title, if such withholding is done pursuant to a request made in accordance with section 3402(p)(1) of the Internal Revenue Code of 1986 [26 USCS § 3402(p)(1)] by the person entitled to such benefit or such person's representative payee.

(As amended Oct. 21, 1998, P. L. 105-277, Div J, Title IV, § 4005(a), 112 Stat. 2681-911.)

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RCW 11.96A.020
General power of courts — Intent — Plenary power of the court.

(1) It is the intent of the legislature that the courts shall have full and ample power and authority under this title to administer and settle:

(a) All matters concerning the estates and assets of incapacitated, missing, and deceased persons, including matters involving nonprobate assets and powers of attorney, in accordance with this title; and

(b) All trusts and trust matters.

(2) If this title should in any case or under any circumstance be inapplicable, insufficient, or doubtful with reference to the administration and settlement of the matters listed in subsection (1) of this section, the court nevertheless has full power and authority to proceed with such administration and settlement in any manner and way that to the court seems right and proper, all to the end that the matters be expeditiously administered and settled by the court.

[1999 c 42 § 103.]

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RCW 11.96A.040
Original jurisdiction in probate and trust matters — Powers of court.

(1) The superior court of every county has original subject matter jurisdiction over the probate of wills and the administration of estates of incapacitated, missing, and deceased individuals in all instances, including without limitation:

(a) When a resident of the state dies;

(b) When a nonresident of the state dies in the state; or

(c) When a nonresident of the state dies outside the state.

(2) The superior court of every county has original subject matter jurisdiction over trusts and all matters relating to trusts.

(3) The superior courts may: Probate or refuse to probate wills, appoint personal representatives, administer and settle the affairs and the estates of incapacitated, missing, or deceased individuals including but not limited to decedents' nonprobate assets; administer and settle matters that relate to nonprobate assets and arise under chapter 11.18 or 11.42 RCW; administer and settle all matters relating to trusts; administer and settle matters that relate to powers of attorney; award processes and cause to come before them all persons whom the courts deem it necessary to examine; order and cause to be issued all such writs and any other orders as are proper or necessary; and do all other things proper or incident to the exercise of jurisdiction under this section.

(4) The subject matter jurisdiction of the superior court applies without regard to venue. A proceeding or action by or before a superior court is not defective or invalid because of the selected venue if the court has jurisdiction of the subject matter of the action.

[2001 c 203 § 9; 1999 c 42 § 201.]

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RCW 11.96A.060
Exercise of powers — Orders, writs, process, etc.

The court may make, issue, and cause to be filed or served, any and all manner and kinds of orders, judgments, citations, notices, summons, and other writs and processes that might be considered proper or necessary in the exercise of the jurisdiction or powers given or intended to be given by this title.

[1999 c 42 § 203.]

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Research References

Treatises and Practice Aids

1 Wash. Prac. Series § 26.29, Duties and Powers of Guardian—Performance of Contracts.

11.92.140. Court authorization for actions regarding guardianship funds

The court, upon the petition of a guardian of the estate of an incapacitated person other than the guardian of a minor, and after such notice as the court directs and other notice to all persons interested as required by chapter 11.96A RCW, may authorize the guardian to take any action, or to apply funds not required for the incapacitated person's own maintenance and support, in any fashion the court approves as being in keeping with the incapacitated person's wishes so far as they can be ascertained and as designed to minimize insofar as possible current or prospective state or federal income and estate taxes, permit entitlement under otherwise available federal or state medical or other assistance programs, and to provide for gifts to such charities, relatives, and friends as would be likely recipients of donations from the incapacitated person.

The action or application of funds may include but shall not be limited to the making of gifts, to the conveyance or release of the incapacitated person's contingent and expectant interests in property including marital property rights and any right of survivorship incident to joint tenancy or tenancy by the entirety, to the exercise or release of the incapacitated person's powers as donee of a power of appointment, the making of contracts, the creation of revocable or irrevocable trusts of property of the incapacitated person's estate which may extend beyond the incapacitated person's disability or life, the establishment of custodianships for the benefit of a minor under chapter 11.114 RCW, the Washington uniform transfers to minors act, the exercise of options of the incapacitated person to purchase securities or other property, the exercise of the incapacitated person's right to elect options and to change beneficiaries under insurance and annuity policies and the surrendering of policies for their cash value, the exercise of the incapacitated person's right to any elective share in the estate of the incapacitated person's deceased spouse, and the renunciation or disclaimer of any interest acquired by testate or intestate succession or by inter vivos transfer.

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The guardian in the petition shall briefly outline the action or application of funds for which approval is sought, the results expected to be accomplished thereby and the savings expected to accrue. The proposed action or application of funds may include gifts of the incapacitated person's personal or real property. Gifts may be for the benefit of prospective legatees, devisees, or heirs apparent of the incapacitated person, or may be made to individuals or charities in which the incapacitated person is believed to have an interest. Gifts may or may not, in the discretion of the court, be treated as advancements to donees who would otherwise inherit property from the incapacitated person under the incapacitated person's will or under the laws of descent and distribution. The guardian shall also indicate in the petition that any planned disposition is consistent with the intentions of the incapacitated person insofar as the intentions can be ascertained, and if the incapacitated person's intentions cannot be ascertained, the incapacitated person will be presumed to favor reduction in the incidence of the various forms of taxation and the partial distribution of the incapacitated person's estate as provided in this section. The guardian shall not, however, be required to include as a beneficiary any person whom there is reason to believe would be excluded by the incapacitated person. No guardian may be required to file a petition as provided in this section, and a failure or refusal to so petition the court does not constitute a breach of the guardian's fiduciary duties.

[1999 c 42 § 616; 1991 c 193 § 32; 1990 c 122 § 32; 1985 c 30 § 10. Prior: 1984 c 149 § 13.]

Historical and Statutory Notes

Part headings and captions not law—Effective date—1999 c 42: See RCW 11.96A.901 and 11.96A.902.

Effective date—Severability—1991 c 193: See RCW 11.114.903 and 11.114.904.

Effective date—1990 c 122: See note following RCW 11.88.005.

Short title—Application—Purpose—Severability—1985 c 30: See RCW 11.02.900 through 11.02.903.

Severability—Effective dates—1984 c 149: See notes following RCW 11.02.005.

Laws 1985, ch. 30, § 10, reenacted the section without change.

Laws 1990, ch. 122, § 32, throughout the section, substituted "incapacitated" for "incompetent or disabled"; and, in the first paragraph, preceding "other than" deleted "collectively hereafter referred to in this section as 'incompetent' "; and, near the end of the first paragraph, following "state or federal income taxes," inserted "permit entitlement under otherwise available federal or state medical or other assistance programs,".

Laws 1991, ch. 193, § 32, in the second paragraph, near the middle, inserted the phrase pertaining to the establishment of custodianships for the benefit of a minor.

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RCW 11.92.010
Guardians or limited guardians under court control — Legal age.

Guardians or limited guardians herein provided for shall at all times be under the general direction and control of the court making the appointment. For the purposes of chapters 11.88 and 11.92 RCW, all persons shall be of full and legal age when they shall be eighteen years old.

[1975 1st ex.s. c 95 § 18; 1971 c 28 § 5; 1965 c 145 § 11.92.010. Prior: 1923 c 72 § 1; 1917 c 156 § 202; RRS § 1572. Formerly RCW 11.92.010 and 11.92.020.]

Notes:

Age of majority: RCW 26.28.010.

Married persons deemed to be of full age: RCW 26.28.020.

Termination of guardianship or limited guardianship upon attainment of legal age: RCW 11.88.140.

Transfer of jurisdiction and venue: RCW 11.88.130.

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RCW 11.96A.150
Costs — Attorneys' fees.

(1) Either the superior court or any court on an appeal may, in its discretion, order costs, including reasonable attorneys' fees, to be awarded to any party: (a) From any party to the proceedings; (b) from the assets of the estate or trust involved in the proceedings; or (c) from any nonprobate asset that is the subject of the proceedings. The court may order the costs, including reasonable attorneys' fees, to be paid in such amount and in such manner as the court determines to be equitable. In exercising its discretion under this section, the court may consider any and all factors that it deems to be relevant and appropriate, which factors may but need not include whether the litigation benefits the estate or trust involved.

(2) This section applies to all proceedings governed by this title, including but not limited to proceedings involving trusts, decedent's estates and properties, and guardianship matters. This section shall not be construed as being limited by any other specific statutory provision providing for the payment of costs, including RCW 11.68.070 and 11.24.050, unless such statute specifically provides otherwise. This section shall apply to matters involving guardians and guardians ad litem and shall not be limited or controlled by the provisions of RCW 11.88.090(10).

[2007 c 475 § 5; 1999 c 42 § 308.]

Notes:
Severability -- 2007 c 475: See RCW 11.05A.903.

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